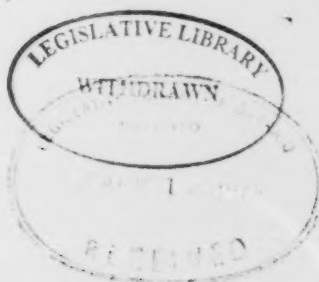


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Joint Ministerial Task Force on
Services for Senior Citizens
in Saskatoon and Rural Community
City Hospital
Queen Street and 7th Avenue
Saskatoon, Saskatchewan S7K 0M7
August 15, 1978

The Honourable H. H. Rolfes
Minister of Social Services
and
The Honourable E. L. Tchorzewski
Minister of Health
Regina, Saskatchewan

Dear Ministers:

We, the members of the Joint Ministerial Task Force on Services for Senior Citizens in Saskatoon and Rural Community, are pleased to transmit to you our final report.

We were pleased to have been able to examine the issue of services to senior citizens for your consideration. We believe this field to be of increasingly vital importance from both a humanitarian and financial point of view, and we hope that our recommendations will contribute in some way to the improvement of services to the elderly.

We are aware that our Task Force was given the opportunity to look at the entire spectrum of health and social services for senior citizens for the purpose of developing a comprehensive and rationalized pilot project for Saskatoon and the adjacent rural municipalities. As such, this report addresses issues and makes recommendations which, if acceptable to Government and the communities in the area, might in at least some aspects serve as a model for similar developments throughout the province. In light of the potential importance of our work, we have striven throughout the course of our deliberations and particularly in the report itself to render our discussions and conclusions as clear as possible.

We have proceeded in this fashion in order to make the report as universally accessible as can be expected of a document whose subject is at least partially technical, and is in most aspects rather complex. While some of the discussions of issues may appear rather laboured to health and social service planners and professionals, we have decided that perhaps local groups and individuals might appreciate a careful, step by step account of our progress toward the recommendations. Should planning groups be established in other parts of the province, they will likely have to address the same, or similar issues and problems as those we encountered in our service District. However, the demographic and urban/rural characteristics of Saskatoon and the adjacent municipalities may not be strictly comparable to those elsewhere, with the result that our recommendations may not be wholly adaptable to other jurisdictions.

We wish to emphasize that we view our recommendations as an integrated package pertaining to the entire area of health and social services for senior citizens. It does not appear to us to be feasible to implement only selected recommendations to the exclusion of others. Rather, in an effort to advocate a program designed to shift emphasis and resources from the institutional to the community service sector, we have developed a comprehensive set of proposals, all of which, if properly conceived, contribute to this general goal. In particular, we regard the establishment of a District coordinating office as an essential prerequisite without which meaningful and equitable change will be severely hampered, if not indeed impossible.

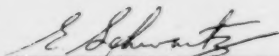
In addition, we strongly urge that our proposals be evaluated in the context of long range demographic and financial patterns and program goals. While we are recommending new expenditures in the short term which may not effect significant savings in the service system immediately, we are quite convinced that the proposals will bear substantial fruit if given a real opportunity to prove their worth. In brief, our main financial suggestion is to spend a limited amount in the near future to save or pre-empt huge potential expenditures which will be required unless certain aspects of service delivery and philosophy are reoriented.

The Task Force convened a number of meetings to discuss a number of the most important proposals with senior citizens' groups, community based and institutional service organizations, and representatives of the rural area involved. We also held discussions with the Saskatoon Provisional Board of Health and its advisory staff. In general, we heard little significant opposition to the general coordinating principles underlying the recommendations. In fact, many of our proposals are fully compatible with suggestions which have been discussed and advocated by community groups in both formal and informal manner.

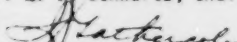
Nevertheless, we feel obliged to advise you that as we are advocating a number of crucial changes, there may well be some reluctance toward their implementation. There is inevitably some resistance to change where so many organizations and interests are involved. We would be remiss if we did not acknowledge that some of our proposals will be seen as controversial. We are unanimously convinced, however, that we are recommending the minimum changes necessary to achieve the desired results in terms of quality of life for the elderly and efficiency of service delivery. If this is indeed the case, it will be worthwhile to make a firm commitment toward taking the appropriate steps, even if the transitional phase is not entirely smooth.

Having stated this, we do not wish to sound unnecessary alarms. We have been impressed with the desire of virtually all organizations to work toward common goals. There is close to unanimity of opinion in the community concerning the need to rationalize certain procedures and to control spiralling service costs. If sensible steps are taken to overcome the most pressing problems, we have complete confidence that a comprehensive pilot geriatrics project can be successfully and cooperatively developed.

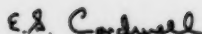
All of the Task Force members found this work both stimulating and rewarding. We are also aware that either the Government or other groups may wish to discuss certain aspects of our deliberations and recommendations as other developments begin to take place elsewhere. Within reason, we would be delighted to assist where appropriate, bearing in mind, of course, the constraints imposed by our everyday occupational demands.



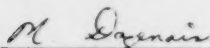
Mr. E. H. Schwartz, Chairman



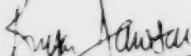
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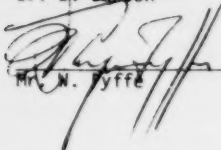
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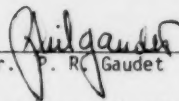
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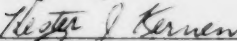
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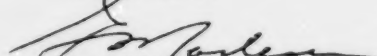
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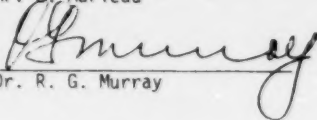
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ACKNOWLEDGEMENTS

The preparation of this report required not only the full participation of the Task Force itself, but also a number of other individuals and agencies, and it is only appropriate that their contribution be acknowledged.

We are grateful to the many people in the provincial Department of Health and Department of Social Services who provided background material essential to our deliberations. The staff of the Senior Citizens' Provincial Council was also very helpful in this regard.

We also wish to thank all those individuals and groups who met with us to discuss various aspects of program design. In particular, the Panel of Experts gave willingly of their time and knowledge, and we believe that our report benefited substantially from their counsel.

We were most fortunate to obtain the services of Janice Humphries and Cheryl Hornseth of City Hospital, who patiently and expertly typed the final version.

The Task Force members were unanimous in their praise of Mr. Steven Lewis, Task Force Research Director, and his assistant, Marion Harrison. Steven and Marion worked unstintingly to provide the Task Force with much of the information required prior to making decisions and recommendations. Without their cooperation and hard work this report could not have been completed within the very tight schedule we established.

ABSTRACT

The Joint Ministerial Task Force on Services for Senior Citizens in Saskatoon and Rural Community was established to develop a proposal for a demonstration geriatrics project. The Task Force assembled in January, 1978, and was to report to the Minister of Social Services, Hon. H. H. Rolfes, and the Minister of Health, Hon. E. L. Tchorzewski, by September 1, 1978.

The Task Force examined the entire spectrum of health and social services for the elderly, from basic preventive and home care services in the community setting through to extensive chronic care in institutions. A formally constituted Panel of Experts and a wide range of documents provided background material on which many of the recommendations took shape. As well, the Task Force met with service organizations and senior citizens in the project area.

The program proposals extend to a District forming a radius of 30 to 35 miles around, and including, the City of Saskatoon. Total District population is 160,000, of whom 15,000 are aged 65 and over.

The main recommendations include the shifting of resources and attention away from long term institutional care toward community based services, and the establishment of a District coordinating authority to effect this shift through the development of a system wide assessment and placement service geared toward maintaining client independence wherever feasible. Traditionally, Saskatchewan has had a four level classification system for long term care clients, beginning with minimal supervisory care and extending to intensive direct care. It is recommended that Levels 1 and 2 care, involving 20 and 45 minutes of care per resident per day respectively, be phased out of the institutional sector. To achieve this, home care and other community services should be expanded to reach their maximum preventive and care potential.

It is also recommended that all prospective clients of publicly funded community based and institutional programs undergo a common assessment process so that those in greatest need of services will be placed in programs first, with an emphasis on retention of independence. This process should allow the gradual phasing out of Levels 1 and 2 institutional care, and will provide a system wide perspective of service gaps and needs which can be responded to in a rational manner.

Assuming a constant elderly population, the new policies would result in a saving of over \$0.25 million annually, this figure being the sum of reduced institutional costs and increased community service costs. There would be 1,000 long term beds compared to 1,575 at present serving senior citizens both within and beyond the District boundaries. Home care caseloads could rise from 400 at present to 1,300 or more in the long run, 900 of whom would be senior citizens. A Geriatrics Assessment Unit at University Hospital, Day Centres attached to nursing homes, and a Day Hospital at University Hospital will provide additional assessment and

therapy facilities, with an emphasis on rehabilitation. Public housing will be reoriented toward sheltered housing in which extensive community services and design features will enable incapacitated elderly to remain in the community.

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SUMMARY OF FINDINGS AND RECOMMENDATIONS

The Task Force examined services to senior citizens in Saskatoon from three main perspectives:

1. Current and projected demographic characteristics.
2. Existing health and social service inventory and projected demands and allocation of resources.
3. Current organizational structures and required changes.

Major Findings

- * The senior citizen population in Saskatchewan, already 11% of the total, will rise substantially during the next twenty to fifty years. Some estimates predict that 1 in 5 citizens will be 65 or over in the foreseeable future. The largest increase will occur among females aged 80 and over, a group that typically will be widowed and in need of a wide range of services of varying intensity.
- * Given demographic trends, any shift in resources from the institutional sector to the community sector will in the long run not reduce the absolute need for institutional programs. Rather, the major effect will be to prevent the need for certain additional institutional services to accommodate the increased elderly population. Assuming a constant number of senior citizens, there should be a significant decrease in Levels 1 and 2 utilization in the near future. In the long run, these Levels should be eliminated as expanded community based health and social services are put in place.
- * There is currently a reasonably wide range of health and social services available in the District, particularly in Saskatoon. It is impossible, given the current status of data collection and program evaluation, to ascertain precisely the adequacy of community and institutional services. It is apparent, however, that the community services have not exerted a substantial preventive effect on the need for special and extended care beds, as roughly 8% of the elderly population is institutionalized. The already planned expansion of home care and the implementation of innovative community programming should proceed as soon as possible in order to effect the desired shift toward community care.
- * The Home Care District as envisioned by the Department of Social Services appears to be a reasonable service area, with no residents more than 30 to 35 miles from Saskatoon. This is the recommended District for the geriatrics pilot project.
- * Institutional, housing, and community services are provided in relative isolation, and it is difficult for clients to move back and forth along the service continuum. While there are some good referral relationships and joint provision of services at present, by and large clients and service providers do not take into account all possible care alternatives in making

placement decisions, and the emphasis is still on institutional accommodation.

- * Public housing in the District serves primarily an economic purpose. There has been little emphasis on the sheltered housing concept where the need for care is a crucial element of admissions policy and relatively intensive home services can be delivered efficiently, preventing the need for institutionalization in many instances. The continued existence of Levels 1 and 2 care is largely a result of the absence of viable housing alternatives combined with community services.
- * There is no coordinating authority responsible for ensuring that services are delivered appropriately, efficiently, and in a manner subject to equitable monitoring and evaluation. Funding mechanisms are similarly fragmented.
- * The assessment, referral, placement, and care coordination procedures are non-standardized: only Level 4 admissions are regionally screened and monitored. Some programs have fairly refined assessment criteria, while others have virtually none.
- * There is no comprehensive set of standards for community service programs, although certain organizations have developed criteria for quality control. Standards for institutional care are quite basic, and by and large do not take into account varying client needs and prospects for rehabilitation within the same level of care.
- * Client charges for services are established haphazardly, with no uniform criteria, particularly for community based services. In some instances, the client charge system encourages either administrators or clients and their families to effect placements at higher levels of care, when the theoretical goal of the system is to encourage greater self-reliance and independence.
- * There must be a District coordinating authority with jurisdiction over funding, client assessment and placement, and program evaluation in order for significant shifts in resource allocation to take place. Additional short term and interim expenditures will be necessary to effect long run savings, assuming a constant population; and in reality, all expenditures will increase as a result of demographic trends. The streamlining of certain procedures should make it possible to shift some of the fragmented bureaucracy to the District level at no extra cost.
- * Immediate shifts away from the institutional sector cannot be expected, as expanded community based services must be in place for there to be viable alternatives to institutionalization.

Recommendations

1. Both short-term and long-term home care should be expanded to reach their optimum preventive and rehabilitative potential, in line with basic Provincial Government policy guidelines and with initial em-

phasis on the core services including homemaking, nursing, meals on wheels, and handyman/repair.

2. Physical therapy, occupational therapy, and community psychiatric services should be developed to deliver maximum benefits to the elderly, with particular emphasis on rehabilitation and the retention or recovery of independence in all possible instances.
3. Special and extended care homes should develop day centers and activity centers in response to identified needs so that services such as physical and occupational therapy and meals can be delivered on a group basis with maximum economic efficiency and effective deployment of staff.
4. Acute care facilities should develop day hospitals following demonstration of the utility and efficiency of the Moose Jaw, and perhaps University Hospital pilot projects, for the purpose of providing a sophisticated range of services to senior citizens on an outpatient basis.
5. The appropriate health professionals should pay renewed attention to the issue of foot care so that problems which may lead to loss of mobility among senior citizens can be detected and treated as soon as possible, and measures can be taken to reduce the discomfort resulting from problems too advanced for preventive intervention.
6. The Geriatrics Program Directorate should plan a transportation system accessible to incapacitated senior citizens and the young disabled, in consultation with the appropriate agencies and potential users, taking into consideration the role of transportation in the continuum of community oriented services; interim options designed to alleviate the most pressing problems; and a long range master plan developed in coordination with existing transit facilities, with a view to keeping both client and publicly borne costs at a reasonable level.
7. The entire field of psychogeriatrics should be emphasized to achieve the elimination of stereotypes surrounding mental health and the elderly; the encouragement of more intensive non-institutional diagnosis and treatment of mental disorders; the review of current services available to the elderly by the Psychiatric Services Branch of the Department of Health in view of conflicting approaches to treatment; the establishment of standards for both the integration and segregation of psychiatric patients, depending on the likelihood of disruptive effects on other patients, programs, and environments. A review of protective services and practices should accompany this effort.
8. Independent housing stock should be conceived as part of the continuum of facilities suitable for care of the incapacitated elderly, and policies should be developed in the context of a shift in the focus of care from the institutional to the community sector.

9. All existing funding programs for senior citizens' household modification and repair should be reviewed jointly by the Saskatchewan Housing Corporation, the Department of Health, and the Department of Social Services to assess their role in promoting independence and their effect on the demand for institutionalization; and if necessary, a new independent housing policy should be developed with funding provisions taking into account the benefits of improving existing stock, and the potential of an expanded program for reducing the need for costly institutional care.
10. The province should establish a policy whereby public housing is considered an integral component in the care system, with the potential for replacing Levels 1 and 2 facilities.
11. The province should make use of those sections of the *National Housing Act* which allow for appropriate flexibility in design and funding of features to accommodate the incapacitated, in line with a general policy of reorienting public housing as a locus of moderate to intensive community care.
12. The province should endorse the concept of sheltered housing, with funding for resident supervisors; electronic communications features for purposes of routine and discreet supervision and emergency calls; design of access ramps, hallways, kitchens and bathrooms to accommodate significantly disabled persons; and community care program offices on the main floor as an added safety and care provision.
13. Admissions criteria should be established according to which the need for community services and availability and cost of alternatives are given considerable weight, with secondary emphasis on ability to pay; and waiting lists should be coordinated with the priorities criteria established throughout the community and institutional service system.
14. There should be formal liaisons between institutional facilities (primarily Level 3) and public housing projects to facilitate movement back and forth along the continuum of care in response to improvements or deterioration in condition.
15. Levels 1 and 2 care in institutions should ultimately be eliminated, given the expansion of community care programs and revised housing policies.
16. Institutionalization should begin with what is now Level 3 care in the long run, and all institutionalization should fall under a single classification category with rationalized delivery of service and funding structures.
17. A target of 5% institutionalization among the elderly should be set for the project area, involving 1,000 beds, the decrease resulting from

attrition among Levels 1 and 2, but given demographic trends, a master plan should be developed for adding new beds suitable for Levels 3 and 4 through conversion of existing facilities.

18. Facilities should be encouraged to provide a suitable range of services to look after the health and environmental needs of their clientele, with minimal movement between institutions.
19. At least two institutions offering Level 3 and 4 care should be funded for designating a total of 8 to 10 beds as "flexibeds" to accommodate urgent needs immediately.
20. In the long run, all institutions should provide vacation beds for use by clients on a short-term basis while their families or other sources of care are temporarily absent.
21. There should be a single authority responsible for defining standards, monitoring care, and enforcing regulations pertaining to private special care homes.
22. Policies regarding client assessment and placement, short- and long-term funding and subsidization, and program monitoring and evaluation should apply to private special care homes as well as other components of the community and institutional system of care.
23. The possibility of establishing formal affiliations between private and larger special care homes should be explored.
24. Hospitals and staff should develop plans to rationalize the admissions criteria and to improve the accuracy of diagnostic and treatment services to senior citizens as part of a general effort to increase the emphasis of geriatric medicine.
25. The Geriatric Assessment Unit at University Hospital, if approved, should be closely monitored and evaluated to ensure that it is able to carry out assessments for prospective Level 4 clients; provide intensive diagnostic services to community residents on a rationalized admissions basis; and provide access to a suitable range of community physicians on a direct or indirect basis.
26. The basic home care services of homemaking, nursing, meals on wheels, and handyman/repair should be delivered locally in the rural areas.
27. Other services should be delivered on a decentralized basis to the rural areas provided that there is sufficient demand, and unit costs do not unreasonably exceed the alternative cost of providing the services in Saskatoon.
28. Where services are provided centrally in Saskatoon, provision must be made for adequate transportation of rural residents to and from the city to maintain reasonable accessibility to facilities.

29. The home care program should be expanded over three years to become capable of handling an average caseload of 1,300 post acute care and long-term clients, of whom 900 to 1,000 will be senior citizens; but the expansion should take place based only upon clearly identified needs.
30. Day hospitals should be planned as part of the continuum of care once demonstration projects have proved their worth, with provision for 20 to 30 places in the area in the long run.
31. The Sherbrooke Community Day Centre should be evaluated, and if it proves successful, an additional center should be provided in the city to expand total capacity to 100. There should also be provision for delivering comparable services to rural centers, or transporting rural clients to urban facilities.
32. A long-range goal of 750 sheltered housing units should be set, involving modification of existing units, construction of new units, or both; and some of these units should be located in the rural area, based on demand.
33. There should be a long-range goal of 1,000 institutional beds for senior citizens, based on 5% of the population over 65.
34. There should be 200 to 250 Level 4 and 750 to 800 Level 3 beds for senior citizens, based on current demographic data and perceived imbalances in the system; but the Level 4 proportion may be expected to increase as the number of very old residents increases, with a concomitant need for more beds in total.
35. The Division of Geriatric Medicine at the College of Medicine of the University of Saskatchewan should serve as the focal point for education in gerontology among all health professionals, with academic and clinical resources available to an appropriate range of students.
36. All health professions should as a matter of course become generally more oriented toward the elderly in recognition of the changing nature of the population and the prevalence of health problems among senior citizens.
37. All family physicians should devote a considerable proportion of their time to senior citizens as part of the effort to meet the high service needs of this segment of the population, regardless of whether specialized geriatricians are trained in the province.
38. The Medical Care Insurance Commission should review payment criteria for geriatric assessment with a view to making the necessary adjustments to encourage physicians to take the time to perform appropriate work-up and diagnosis of problems peculiar to, or more complex among, the elderly.

39. Interns, residents, and other health professionals should be rotated through Level 3 and 4 institutions as part of their training course, bearing in mind the need to maintain licensing status in other areas and to meet accreditation standards set by national bodies.
40. The development and use of volunteers throughout the service system should be encouraged.
41. There should be a District Volunteer Coordinator to promote the greater use of volunteers, especially in community service programs; to coordinate seminars on the expanded training and deployment of volunteers in innovative areas; and to provide assistance to volunteer coordinators in the system as necessary.
42. The provincial, and perhaps the federal government should develop a tax credit plan to recognize volunteer work as a form of charitable donation.
43. The governing authority for the geriatrics program must be capable of administering home care funds; delivering services to the rural areas as a legitimately perceived authority; actively designing and implementing the required innovations and procedures vital to the success of the program; recruiting capable program staff; coordinating geriatric services with the general health system; and beginning program development as soon as possible.
44. A Board of Health able to discharge the required duties with appropriate legislative authority in the District should be the governing authority for the geriatrics program, as well as other health services.
45. There should be no duplication of governing authorities for health services in the district unless the Board of Health is unable to develop the geriatrics program, including home care, in the desirable fashion; in which case the geriatrics program should initially come under the authority of an Interim Geriatrics Board which might report to the Provincial Government, with provision for the transfer of its authority to the Board of Health after a specified time period.
46. Activities necessary to promote economic efficiencies, systemic accountability, desired procedural uniformity, and similar benefits should be centralized.
47. Any activities which can be carried out on a decentralized basis, bearing in mind the principles listed in Recommendation 46, should be decentralized, with a view to providing all services, and as much of the administration as possible, without the need for additional central bureaucracy.
48. Budgeting for home care and other community based geriatrics services should be handled through the District Office Administrator; global grants from funding sources should be turned over to the governing Board, for dispersal to service organizations.

49. Services should be procured and delivered on a contract basis, negotiated initially by service agencies and the Administrator and approved by their respective Boards.
50. The District Office should not directly administer any service programs unless specifically requested to do so by service providers, and if it is economically efficient to do so.
51. Initially, direct budgeting authority should apply to the community sector, with an advisory role to Government regarding the institutional and housing sectors; but in the long run, the Board of Health should perhaps have funding authority throughout the service continuum to ensure maximum coordination and efficiency.
52. There should be a mandatory District Assessment, Placement, and Case Coordination service extending to all prospective clients of community service programs, public housing, and Levels 1 to 4 institutions, where public funds are involved directly or indirectly.
53. There should be a Director of Assessment and Placement responsible for designing, testing, and implementing the system, recruiting appropriate staff, and monitoring the system once operational.
54. There should be a District Assessment and Placement Unit capable of handling 2,000 cases annually, including 4 public health nurses, 2 social workers, 1 physical therapist, 1 occupational therapist, 6 medical consultants, and other consultants as necessary.
55. The 3 assessors from the University Hospital Home Care program, 2 Levels 1 to 4 assessment personnel, and 3 Department of Social Services assessment personnel should be shifted to the proposed District Unit.
56. There should be an Assessment Advisory Board, composed of representatives of service organizations and perhaps consumers, to monitor Unit operations, ensure adequate communication throughout the system, and propose changes in policy.
57. The Geriatrics Assessment Unit should assess all prospective Level 4 clients, and their equivalents assuming the classification system is revised in the long run; and it should report its findings in order of priority to the District Unit.
58. Assessment personnel should also perform the case coordination role, involving the provision of advice and supervision to service personnel; reassessment of clients as necessary; and addition or cancellation of services as needed.
59. Clients should retain complete freedom to use or refuse recommended services, or to avoid the standard procedure if willing to pay the entire unsubsidized cost of independently procured services.

60. At the present time, no more than 10% of special care home beds should be designated as preferred accommodation accessible to clients without assessment.
61. There should be a formal appeal mechanism against decisions and recommendations made by the Assessment Unit.
62. There should be a Director of Standards to develop a comprehensive set of regulations governing the delivery of geriatric services during the start-up phase.
63. This position should be seconded by the provincial Home Care Directorate in recognition of the importance of the development stage for the entire province; the desirability of avoiding duplication of function; and the one time only nature of the need to undertake this activity on a comprehensive basis.
64. Standards should be set governing permissible administrative proportions of total service costs; minimum quality of services, with provision for exceeding them at additional cost if desirable; and quantity of service deliverable to clients, based on priority of needs and alternatives available.
65. Special consideration should be given to the rural areas so that, within reasonable limits, standards may be flexible enough to take into account a desire for locally delivered services on a reduced or limited basis in preference to travelling to Saskatoon for more sophisticated and extensive programs.
66. An information gathering and program monitoring and evaluation package should be developed for the geriatrics program in consultation with service organizations, academics, and other potential users of the system, with one position seconded from the provincial Home Care Directorate during the developmental stage.
67. The data system should be sufficient to record assessment and placement information, service delivery information, outcomes resulting from service provision, and appropriate demographic information, with the capability to yield individual organization and comparative evaluation, possible target groups for routine screening and assessment, and indications of service gaps and deficiencies.
68. The system should be computerized, with appropriate safeguards regarding confidentiality and provision for meeting additional needs of individual agencies.
69. The District information and evaluation system should not preclude individual organizations from retaining their own records and evaluating their own programs in accordance with particular needs and desires, with help from District staff if requested.

70. Regardless of which authority will govern the geriatrics program in the short run, the Board should be in place by March 31, 1979.
71. Recruitment of District staff and development of forms, standards, procedures, and relationships with service organizations should take place between October 1, 1979 and March 31, 1980.
72. The geriatrics program should be fully operational as recommended by the fiscal year beginning April 1, 1980.
73. The geriatrics program authority in conjunction with District institutions and provincial funding sources should develop a long range master plan for financing institutional beds, with provisions for funding of short-term bed vacancies and conversion of facilities to the appropriate uses.
74. All duly assessed institutional residents should pay a flat rate room and board charge of \$250 per month, with all health services fully insured by the province, for Levels 1 to 4 care as presently structured in the short run, and under a revised classification system in the long run.
75. Client charges for community services should be rationalized, with strictly health related services fully insured, and charges assessed for ancillary services provided that rates do not inhibit senior citizens from using recommended services nor encourage institutionalization for purely financial reasons.

CHAPTER 1

INTRODUCTION

The Joint Ministerial Task Force on Services for Senior Citizens in Saskatoon and Rural Community was established in January of 1978 by the Minister of Health, the Honourable E. L. Tchorzewski, and the Minister of Social Services, the Honourable H. H. Rolles, of the Government of Saskatchewan. Its mandate was to design a program proposal of services to the elderly on a pilot basis in Saskatoon and surrounding area.

The original proposal for such a Task Force emanated from the Report of the Committee on Service Funding of the College of Medicine at the University of Saskatchewan, which urged that a service program be developed to complement the educational thrust toward the elderly undertaken by the establishment of the Division of Geriatric Medicine at the University.

The Terms of Reference (see Appendix 1 for complete details) required the Task Force to address 5 main issues:

1. types and volumes of services needed,
2. organizational measures needed to develop an efficient program,
3. educational resources needed for staff involved,
4. the implementation schedule for the program,
5. the financial implications of the recommendations.

As a general principle, the Task Force was to concentrate on organizing existing services in the most efficient manner rather than adding a large new bureaucracy. The major emphasis was to be on shifting institutional resources to community based services wherever feasible, in line with contemporary health care orientation.

It soon became apparent that the Task Force was charged with developing a program whose scope and nature was unprecedented in Canada. The examination of model programs in Britain and the Scandinavian countries proved useful and suggested a number of details and principles worthy of emulation. However, program development in European countries has taken place in the context of different cultural, geographic, and economic conditions. One should therefore be cautious in advocating elements of program design which may not be adaptable to circumstances unique to Saskatchewan. The Task Force found itself in the position of having to consider a number of features largely untried in this country, and determined that whatever model was ultimately recommended should above all take note of, and be compatible with local conditions.

The Task Force was fortunate in that it was able to meet with a wide range of professionals able to contribute their expertise to the deliberations (see Appendix 4 for complete list of consultations). A formally appointed Panel of Experts (see Appendix 1 for membership) presented views on various aspects of the aging process and priorities for service development, as well as providing background information on the Saskatchewan and local scenes. In general, the Panel provided the foundation for several of our recommendations, and we are pleased to acknowledge the experts' contributions to whatever virtues this report possesses. This being said, we must add that we may not have produced recommendations whose nature, emphases, and scope meet with the complete approval of the entire Panel. In thanking members for their contributions, we hasten to add that the Task Force alone is formally responsible for the contents of the report.

We were also able to spend a full day discussing the general field of geriatric medicine and program design for the elderly with Dr. J. C. Brocklehurst, a British Gerontologist who will head the Division of Geriatric Medicine in its first year of operation beginning September 1, 1978. The session was in our view fruitful, and we look forward to the development of a good relationship between the academic and service components of the geriatrics program.

The Task Force also met with senior citizens organizations, community service groups, officials from institutions, and a broad representation from the rural area surrounding Saskatoon. Four sessions were convened in late May for the purpose of discussing certain proposals and options which the Task Force had been considering during the previous months. We thought it essential to communicate our tentative conclusions with these groups so that our report would contain recommendations meeting with the approval of at least a significant majority of those who will either deliver or receive services.

These public meetings comprised the second phase of the consultation process begun earlier with the distribution of a questionnaire designed to assemble a complete health and social services inventory for the area in fulfillment of one of the Terms of Reference. The Task Force developed an extensive series of questions with a view to finding out not only how programs operated in terms of funding, clientele, purpose, and outcome, but also what community opinion had to say about both the present performance of the service system, and the probability of achieving a rationalization of programs in the future. It was thought desirable to try to obtain as much information as possible in this way so that the Task Force would have comprehensive data available prior to holding the public meetings. The Questionnaire, Instruction Manual, mailing list and survey write-up, can be found in Appendices 2A to 2D.

Two researchers were available to the Task Force to compile information, examine program components from other jurisdictions, and provide secretarial help. A series of reports, background papers, and organizational option papers were distributed either at or between meetings so that Task Force members could focus discussion and debate of various possibilities

following a review of prepared material. In this way, a large proportion of work could be done between meetings, and members could ponder certain issues at length before stating preferences in group sessions.

Despite the diversity in the membership and the magnitude of the project, a remarkable degree of consensus developed as time went on. All members came to view the task within the same holistic framework, and once basic principles of program theory and organization had been worked out, the remaining decisions concerning more precise details and options were reached by unanimous consent. As such, this report is the combined and willing product of all Task Force members.

Although the originally designated deadline of September 1 left little room for leisurely progress, the Task Force set for itself an even more industrious schedule. Because it is often difficult to convene meetings during the summer months, it was decided that the vast bulk of the work should be completed by June 30, and particularly agreement on basic program principles and organization, so that all that would remain to be finished would be the redrafting of the final document. Although the pace at the outset appeared to be somewhat slow, the final form of the recommended proposals flowed naturally and swiftly from the earlier, painstaking deliberations.

The format of the report is structured to correspond to the logic of our progress toward the final recommendations. First, we discussed the implications of a large volume of background information received from the Panel of Experts, other consultants, and published sources. We feel that the demographic information is of sufficient import to warrant a separate Chapter. Second, we considered the types and volumes of services required in a basic but comprehensive geriatrics program, within the framework of financial limitations established in the Terms of Reference. Third, once the services had been decided upon, we discussed the organizational structure necessary to implement the program as efficiently as possible, and able to effect the fundamental shifts toward community based services. Finally, we ascertained the financial implications of our proposals, and amended our recommendations to ensure that the new expenditures were the minimum needed to implement a workable program.

In short, we concluded that there are two vital and inseparable components to a comprehensive geriatrics program: services and organization. In our view, the recommendations concerning services cannot be fulfilled without concomitant implementation of the recommendations on organization. In fact, the organizational proposals are quite specifically implied by the service recommendations. When one considers the recommended shifting of resources, often in the face of long standing traditions of care, it becomes clear that organizational patterns and authority structures are crucial. As the financial implications chapter reveals, we believe that in the long run, a shift toward community care will result in savings for the health system. We stress, however, that short run additional expenditures for a substantive coordinating authority must be made if there is to be a reasonable opportunity to effect savings in the long term.

It is necessary from the outset to clarify our understanding of our mandate with respect to the age group to be served. There are two aspects to our concerns.

First, while the Task Force was content to deliberate the nature and scope of services only in reference to the elderly, there proved to be no way to determine precisely what target population is appropriately termed "geriatric". It is commonly assumed, for the sake of convenience and in accordance with widely applied retirement criteria, that one becomes a senior citizen at age 65. While the Task Force was for the most part in agreement with this view, it became apparent through research and consultation with a number of experts that the major problems associated with aging occur primarily in the 75 and over category. Most of the recommendations for services for the elderly will apply mainly to this age group.

Furthermore, it is fundamentally wrong to assume that all senior citizens can be lumped together as a homogeneous group. Dr. Skoll, the Provincial Gerontologist, has indicated that aging can be viewed as a three stage process, the groupings being 65 - 74, 75 -84, and 85 and over. Without interpreting these divisions too rigidly, it may be conceptually valuable to see the age cohorts as corresponding to a need for very little care, increasing community based services, and eventually, some form of institutionalization for the very old.

Although many of our recommendations advocate specific programs and policies for the elderly, it is not our intention to place the onus of screening and care of senior citizens on a designated group of specialists spanning a number of health professions. Specifically, our acknowledgement of the value of a specialty of geriatric medicine does not imply that family practitioners and other specialists are incapable of fulfilling a great proportion of the needs of the elderly population as has historically been the case. Indeed, the Task Force was delighted to hear that the College of Medicine teaches prospective physicians that care of the elderly will become an increasing part of their workload. It would be of no service to the medical profession or the public to urge that all or even most health problems of the elderly be attended to by specialized geriatricians in specialized facilities. For many problems will not be different in kind or effect from those encountered among the rest of the population, and furthermore, the Division of Geriatric Medicine at the University of Saskatchewan should in the future make all physicians more keenly aware of the need to examine elderly clients with appropriate thoroughness with a view to providing the required variations in treatment and referral. The same concept applies, *mutatis mutandis*, to other health and social services professionals as well.

Second, it is not our intention to add yet another layer to the health and social service bureaucracy. In principle, there should be no additions in staff or expenditures unless absolutely warranted. This principle should be carefully interpreted, however, and its application must take into account the long-term effects of rationalizing services. For example, while we are recommending the addition of a number of positions at the District level, we

strongly urge that the savings implied throughout the system as a result of centralizing functions actually take place. In other words, we will not consider our recommendations viable unless some hard decisions are made to fund central positions and functions by *shifting* resources already distributed, albeit haphazardly, throughout the existing service network.

In addition, our organizational proposals are limited somewhat artificially by our mandate to examine services to the elderly. It should be rather obvious that many of our recommendations can be applied to services for the rest of the population as well. We believe we are recommending an organizational structure sufficiently flexible and with enough central resources to oversee a wide range of community services, preferably under the direction of a single Governing Board. This means that we consider our proposals to be complementary to, and not in addition to, the planning efforts of other committees such as the Saskatoon Provisional Board of Health. Indeed, many of the functions to be assumed by the District office for a geriatrics program should also apply to general health and social service programming for the area. Our proposed organizational structure, then, should be able to assume duties in the long run other than those strictly associated with senior citizens programming without significant need for additional staff and resources.

This point cannot be emphasized too strongly. If the Government approves of some or all of our recommendations for funding and staffing, it by implication will have made certain decisions which will constrain to some extent the options for program development and design in non-geriatric areas. We believe that our proposals are able to serve as both a model for, and a first phase of the development of a fully integrated delivery system involving the community agencies and institutions within a given geographical area. It would be unfortunate indeed if either the geriatrics program or other community programs were allowed to develop independently, with accompanying inefficiencies in delivery and continued segregation of the elderly from the population at large and institutional from community based services.

In sum, the Task Force fully agrees with the concept of developing expanded services for senior citizens. We feel, however, that it would be irresponsible to recommend a proposal without reference to the rest of the delivery system, and without keeping in mind the need to obtain the maximum amount and quality of service per dollar spent, with a minimum expansion in bureaucracy.

The terms of reference indicate that the project must extend to an unspecified rural area, a condition with which we are in full agreement. A great deal of discussion took place on the precise extent of project boundaries; in fact, this issue occupied most of our attention in the early stages. Initially, it was our intention to incorporate all of Saskatoon Rural Health Region #8 within the geriatrics program jurisdiction, in anticipation of the possible amalgamation of the city and rural Boards of Health. Given the huge geographical area encompassed by the Rural Health Region boundaries, we concluded that without the prospect of amalgamation with the city

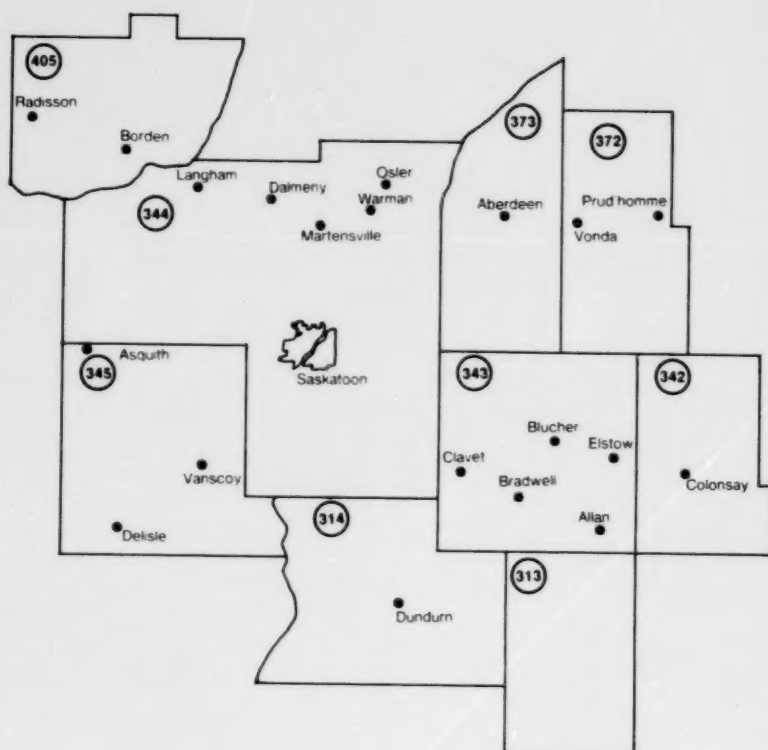
Board of Health in the immediate future, it would be unreasonable to try to implement a pilot project extending as far as 100 miles from Saskatoon.

The other outstanding matter affecting the boundary decision was the announcement of the Home Care program. When the Department of Social Services formally announced plans to proceed, part of the package included a district program structure with established boundaries. As home care is seen as an essential component of the geriatric program, and as the proposed District takes into account natural trading patterns centered on Saskatoon, it became clear that both home care and geriatrics boundaries should be conterminous. Therefore, we decided, not without some regret at having to "abandon" the remainder of the Rural Health Region in the pilot area, that the geriatrics program should be initially implemented in the Home Care District extending some 30 miles outward from Saskatoon (see Figure 1.1). The area involved is of quite manageable size, and allows somewhat more flexibility in the trial stages of the program.

A note on terminology. Wherever "District" appears in capitalized form, the reference is specifically to the project area. More substantively, for the sake of convenience we have used the terms "community" or "community based" to denote some services, and "institutional" services to denote Levels 1 to 6 services. By so doing we do not wish to perpetuate the traditional distinctions and relative isolation of these sectors from each other. Rather, we view all services as fully integrated components of a fluid community continuum, all contributing to individual well being and maximum efficiency in the delivery system. In reality, there are only two kinds of services: institutional community services and non-institutional community services. Our choice of terms reflects aesthetic preference only. Similarly, "health services" means health and social services, which we regard as basically indivisible.

We have used a number of technical terms throughout the report, some of which have a unique meaning in Saskatchewan. We have included a Glossary (Appendix 3) to make as many of these as possible accessible to a general readership.

**Figure 1.1 — Proposed Boundaries of the
Geriatrics Program Demonstration Project.**



CHAPTER 2

SOCIAL, DEMOGRAPHIC, AND UTILIZATION PROFILE

I. INTRODUCTION

This section will provide information on the current and projected status of the elderly population in the demonstration project service area.

The data have been drawn from a variety of sources. Wherever possible, statistics from Saskatchewan sources have been used, as it is assumed that these reflect most accurately the local situation, and are the figures most likely to be accredited for planning purposes. As an example, Saskatchewan Hospital Services Plan (S.H.S.P.) rather than national census figures are used when it is possible to do so.

Some of the information is not available from provincial sources. When this is the case, census figures have been used. While there are some discrepancies between provincial and national statistics for the province, these are relatively minor, and do not adversely affect the main interpretations to be drawn from the data. As an example, the distribution of the elderly within Saskatoon can only be shown using census figures, while the comparable information for the surrounding rural area is available from S.H.S.P. covered population printouts.

The information by itself is meaningless; it is important to our study in that it shows current and projected trends among the elderly population, both in terms of numbers and likely social and health circumstances. We have as a result assembled as much information as possible which indicates both existing and anticipated conditions among senior citizens around which programs must be planned.

Projecting future conditions and program needs is often rather controversial because of the assumptions which must be made in order for predictions to be quantifiably precise. If one argues with certain assumptions regarding migration, fertility, and longevity, one might well dispute the projected demographic trends. The situation is peculiarly volatile in Saskatchewan, where the agriculture based economy has historically resulted in unpredictable migration patterns and fluctuating population patterns. Even long-term population trends may be quite meaningless indicators of what is likely to happen in the foreseeable future in Saskatchewan.

Nevertheless, it is essential to give some indication of the likely trends among the elderly if a geriatrics program is to be properly designed, with the capacity to adapt to anticipated changes in distribution and service needs. We have, therefore, included a number of projections from a variety of sources. It is significant that the projections are all in the same direction,

namely that the elderly will constitute an increasing proportion of the total population, and the very old will increase in numbers much more rapidly than the younger senior citizen category.

A significant amount of comparative information is also included in order to show where the Saskatchewan situation may be unique. If our population is distributed differently from that of other provinces, so too must our resources be allocated differently.

Much of the information is self-explanatory, while other data require some elaboration. Where possible, explanations have been kept short. However, a concluding section deals with both short-and long-term implications of the portrait drawn by the data, and it is this interpretation which should be given greatest consideration. For if the implications are seen as correct, at least part of a comprehensive program structure will be dictated by the analysis of the characteristics of the elderly population.

It is our view that sufficient data are now available for the purposes of planning the demonstration project. There will be future data requirements in order for the program to develop properly. It is suggested that one of the initial tasks of the program directorate will be to convene a working group to ascertain the vital elements in an ongoing data base for senior citizens from which planning, evaluation, and monitoring will emanate.

Where feasible, the information is presented graphically, as this method eliminates the need for lengthy prose and shows historical and future trends. Above all, it is evident that the resource needs of the elderly will grow; what is not as apparent is the precise method by which expanded services should be delivered, and with what potential effects. We caution that while data can reveal a great deal, they cannot alone result in correct policy decisions. The information is rather a basis on which rational and far-seeing decision-making can be built.

II. GENERAL DEMOGRAPHY

A. National Characteristics

Like all industrialized countries, Canada is becoming an increasingly older nation, with large increases in the number of senior citizens. Birth rates have fallen while longevity has increased. The trend will continue in the future, particularly as today's "baby boom" young adults become tomorrow's senior citizens.

The following tables reveal the extent to which Canada's population has, and will continue to become older.

**Table 2.1 — Proportion of Canadian Population
Aged 65 and Over, 1911 to 1971.**

Year	Population Aged 65 + (000's)	Percentage of Total Population
1911	335	4.5
1921	420	4.7
1931	576	5.6
1941	768	6.7
1951	1,086	7.8
1961	1,391	7.6
1971	1,744	8.1

Source: *Federal Provincial Advisory Committee on Community Health. Report, 1976, citing Statistics Canada data.*

Table 2.2 — Population Aged 65 and Over, By Province, 1971.

Province	Total Pop. (000's)	Pop. 65 and Over (000's)	Percent 1971	Percent 1974*
Newfoundland	522.1	32.1	6.1	6.3
P.E.I.	111.6	12.3	11.1	11.1
Nova Scotia	789.0	72.5	9.2	9.4
New Brunswick	634.6	54.7	8.6	8.8
Quebec	6,027.8	413.0	6.9	7.4
Ontario	7,703.1	644.4	8.4	8.6
Manitoba	988.2	95.6	9.7	10.0
SASKATCHEWAN	926.2	94.8	10.2	11.0
Alberta	1,627.9	118.8	7.3	7.5
B.C.	2,184.6	205.0	9.4	9.3
Yukon/N.W.T.	53.9	1.3	2.4	2.4
CANADA	21,568.3	1,744.4	8.1	8.4

*Perceptions Canada, 1977.

Source: Statistics Canada, 1971 Census.

**Table 2.3 — Projected Increase in Canadian Population,
1971 to 2031, by Age.**

Age Group	Numerical Increase	Percentage Increase
0-14.....	1,761,500	27.6
15-24.....	1,355,300	33.9
25-34.....	2,225,700	77.0
35-44.....	2,459,900	97.4
45-54.....	2,525,300	110.2
55-64.....	1,824,300	105.3
65-74.....	2,495,800	231.7
75-84.....	1,483,500	280.1
85+.....	419,000	305.2
ALL AGES	16,550,200	76.7

Source: *Federal Provincial Advisory Committee on Community Health*, Report, August 1976, citing Statistics Canada unpublished data catalogue #91-514, Population Estimates and Projections Division

If the projections are accurate, there will be a significant shift in the distribution of the population toward the higher age groups. By 2031, there will be 4,398,300 more Canadians aged 65 and over than there were in 1971, including an increase of 1,902,500 in the 75 and over category. Much of this increase will occur by 2001, less than a quarter of a century away.

The following tables reveal some of the changes in life expectancy, characteristics of the elderly population, and distribution of the population as a whole that will take place by the end of this century.

**Table 2.4 — Average Life Expectancy at Birth, by Sex,
Canada, 1931 - 1971, Projected 2001.**

Year	Male	Female
1931.....	60.0	62.1
1941.....	63.0	66.3
1951.....	66.3	70.8
1961.....	68.4	74.2
1971.....	69.2	76.1
Projected		
2001.....	72.8	79.1

Source: L. Auerbach and A. Gerber, *Implications of the Changing Age Structure of the Canadian Population* (Science Council of Canada, 1976), citing Statistics Canada data.

Table 2.5A — Distribution of Population 65 and Over by Age Group and Sex, 1971 Actual.

Age Group	Male		Female		Total (000's)
	(000's)	Percent	(000's)	Percent	
65-74	501.7	46.6	575.7	53.4	1,077.4
75-84	225.7	42.6	304.0	57.4	529.7
85+	54.5	39.7	82.8	60.3	137.3
TOTAL	781.9	44.8	962.5	55.2	1,744.4

Source: Same as Table 2.1

Table 2.5B — Distribution of Population 65 and Over by Age Group and Sex, 2031 Projected.

Age Group	Male		Female		Total (000's)
	(000's)	Percent	(000's)	Percent	
65-74	1,584.7	44.3	1,988.5	55.7	3,573.2
75-84	742.8	36.9	1,270.5	63.1	2,013.2
85+	147.3	26.5	408.9	73.5	556.3
TOTAL	2,474.8	40.3	3,667.9	59.7	6,142.7

Source: Same as Table 2.1

Table 2.6 — Median Age of the Canadian Population, 1901 to 2001.

Year	Median Age
1901	22.7
1911	23.8
1921	23.9
1931	24.7
1941	27.0
1951	27.7
1961	26.3
1971	26.3
1981	29.1
1991	32.4
2001	35.7

Source: Statistics Canada, cited in Auerbach and Gerber, *op. cit.*

It is interesting to note that the proportion of the elderly who will be female will increase substantially by 2031, especially for the higher age categories: nearly three-quarters of all Canadians aged 85 and over, and nearly 60% of all senior citizens 65 and over will be female.

B. Provincial and Local Characteristics

A review of available data and projections reveals that national circumstances and trends do not always apply neatly to Saskatchewan. There are patterns unique to this province which suggest that the elderly will become an even more prominent sector of the population than they are now. From 1971 to 1974, the percentage of the population in Saskatchewan aged 65 and over increased from 10.2% to 11.0%, compared to the national figures of 8.1% and 8.4% for the same years. Not only does Saskatchewan have the second highest proportion of senior citizens among all the provinces; our rate of growth among the elderly surpasses all others (see Table 2.2 above).

There are a number of reasons for this phenomenon. Auerbach²¹ reports that interprovincial differences in age structure reflect different levels of economic development and different migration patterns. Saskatchewan, particularly in the early part of the 1970's, experienced a high out-migration rate with the result that in 1971, only 29% of the population was between 20 and 44 years of age compared to the national average of 34%. The older people who remained in the province therefore constituted a higher proportion of the total population than would have been the case had thousands of younger residents not left. While the overall population remained relatively constant between 1966 and 1976, the senior citizen cohort increased by 16.4%. Dr. S. L. Skoll, the Provincial Gerontologist, has estimated that the elderly will comprise 12.8% of the population in 1985 compared to 10.9% in 1976. In other words, in 1965, 1 in 11 Saskatchewan residents was 65 or over; in 1975 the ratio was 1 in 9; while in 1985 it will be 1 in 7.5¹⁴.

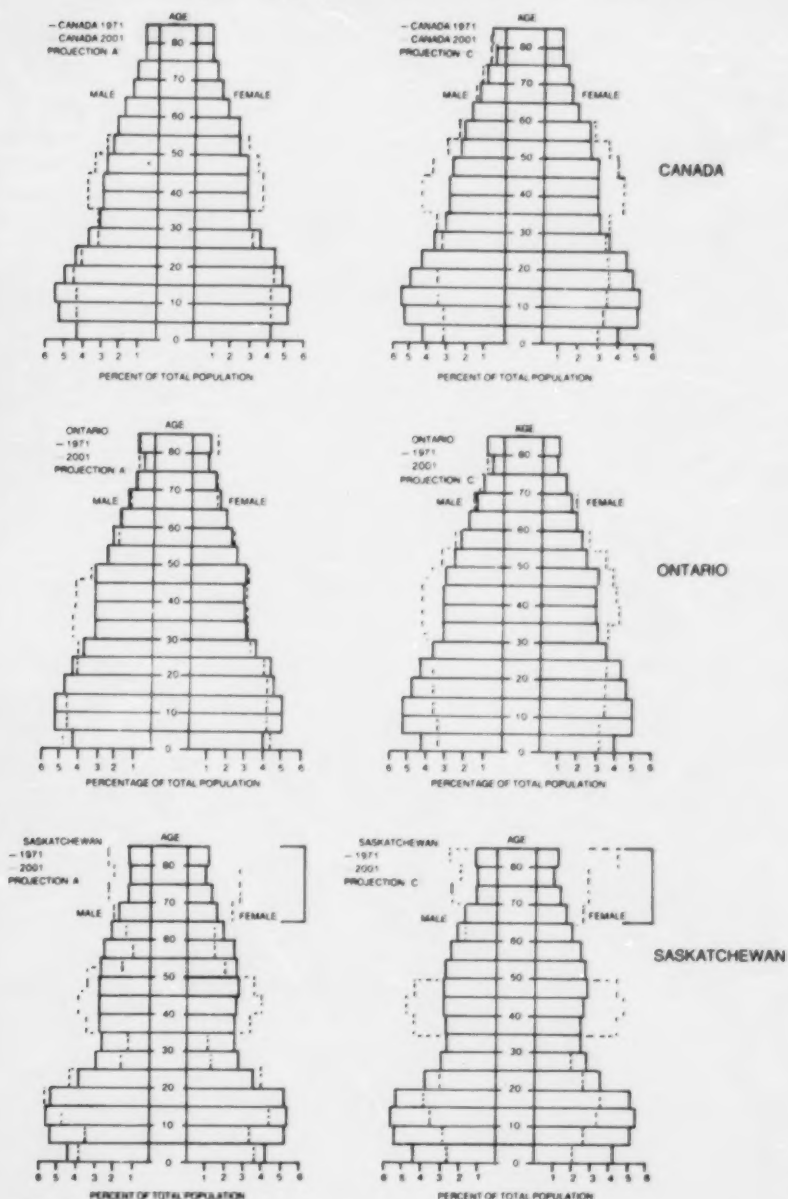
Regardless of what sources are used, it is evident that the elderly are increasing at a rate far in excess of the growth of the rest of the population. The 75 and over group is growing fastest of all. A British Gerontologist, Sir Ferguson Anderson, has stated that "In the future, unless trends change, there will be mainly elderly women, particularly 75 and over, and these old may be very frail and vulnerable."⁵³

Saskatchewan's situation is already distinct from the national average. Differences will be even more dramatic in the future. Figure 2.1 shows the actual and projected age and sex structure of the population in Canada, Ontario, and Saskatchewan. While elsewhere, the size of each cohort generally diminishes with increasing age, Saskatchewan's pyramid will show a bulge in the senior citizen category as a whole, with a great increase in the number of females aged 80 and over (note brackets and arrows on diagrams). In other words, Saskatchewan's population will not only be uniquely skewed toward the elderly in general; as well, our "typical" senior citizen will be older than the national average for this age group. According to Auerbach, "in 2001, . . . more than one-fifth (21 per cent) of Saskatchewan's population will be over 65 years of age and 11-12 per cent will be over 75."²¹ Even if interprovincial migration is cut to one-half its present rate (meaning that this province's net losses due to out-

migration are reduced), over 15% of the population will be elderly in 2001 — 3 per cent above the national average.

The above summary may have implications for the general development of geriatric service programs in Canada and Saskatchewan. The remainder of this descriptive section will concentrate on the service area for the proposed demonstration project: the city of Saskatoon, and municipalities 313, 314, 342, 343, 344, 345, 372, 373, and 405 surrounding the city.

**Figure 2.1 — Age-Sex Structure: 1971
and 2001, in Canada, Ontario, Saskatchewan.**



Fertility (A) 2.60, (C) 1.80
Net migration (A) 100 000, (C) 60 000
Interprovincial migration (A) 450 000, (C) 435 000

Source: Auerbach and Gerber, *op. cit.*

Table 2.7 on the following page shows that the area has a somewhat smaller proportion of elderly than the province as a whole. The major reason for this is that while the less urban areas of the province were hardest hit by the out-migration of the late 1960's and early 1970's, the cities, and particularly Regina and Saskatoon, continued to grow. While the absolute number of senior citizens did increase, the rest of the population increased proportionally. Furthermore, the surrounding rural area is probably not typical of similarly sized rural areas in the province in that there are a significant number of acreages as opposed to large farms close to Saskatoon, and some of the towns have begun to assume the characteristics of "bedroom communities" whose residents commute to and from jobs in the city. All of these factors combine to increase the proportion of younger people in the district.

Figure 2.2 indicates the growth of the 65 and over population in both the city and the surrounding RM's. It is interesting to note that the rise in total elderly population in the city has been almost linear during the past two decades, while the rural growth has been erratic, corresponding to the crests and troughs in the provincial figures over the same period.

Table 2.7 — Number and Proportion of Elderly in Saskatoon and Adjacent Rural Area, by Sex and Age Group.

Age Group	No. Male	No. Female	Total	% of Pop.
SASKATOON — Total population 138,367				
65-69	1,868	2,420	4,288	3.10
70-74	1,540	1,865	3,405	2.46
75-79	946	1,327	2,273	1.64
80-84	623	1,009	1,632	1.18
85-89	357	589	946	.68
90-94	149	237	386	.28
95+	41	74	115	.08
TOTAL 65+ ..	5,524 (42.35%)	7,521 (57.65%)	13,045	9.43
RURAL AREA — Total population 21,778				
65-69	355	342	697	3.20
70-74	237	233	470	2.47
75-79	158	159	317	1.46
80-84	97	105	202	.93
85-89	47	54	101	.46
90-94	11	16	27	.12
95+	2	1	3	.01
TOTAL 65+ ..	907 (49.92%)	910 (50.08%)	1,817	8.34
COMBINED — Total population 160,145				
65-69	2,223	2,762	4,985	3.11
70-74	1,777	2,098	3,875	2.42
75-79	1,104	1,486	2,590	1.62
80-84	720	1,114	1,834	1.15
85-89	404	643	1,047	.65
90-94	43	75	118	.07
95+	160	253	413	.26
TOTAL 65+ ..	6,431 (43.27%)	8,431 (56.73%)	14,862	9.28

Source: S.H.S.P. Covered Population, 1977.

Figure 2.2 — Growth of Population 65 and Over in Saskatoon, 1956-1976.

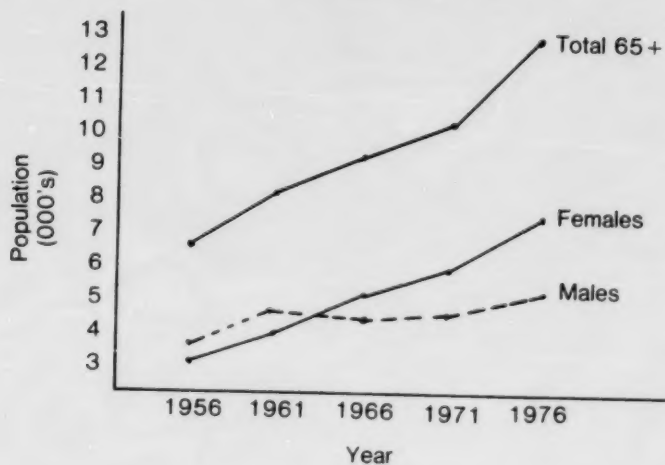
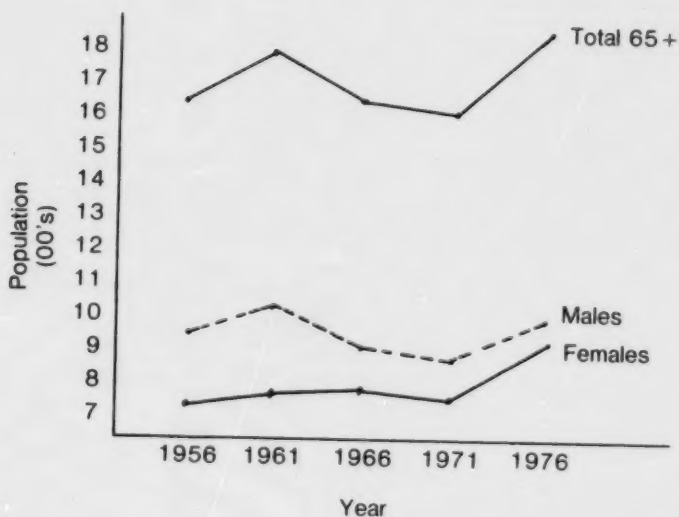


Figure 2.2A — Growth of Population 65 and Over in Rural Area, 1956-1976.



Source: Data from table 2.8.

In the city, the female elderly population surpassed its male counterpart early in the 1960's, and is now significantly larger, while in the rural area, the elderly female population is only now approaching the number of male elderly. The following table shows more precisely these trends.

Table 2.8 — Growth of Saskatoon and Rural Area Overall and Elderly Population 1956 to 1976.

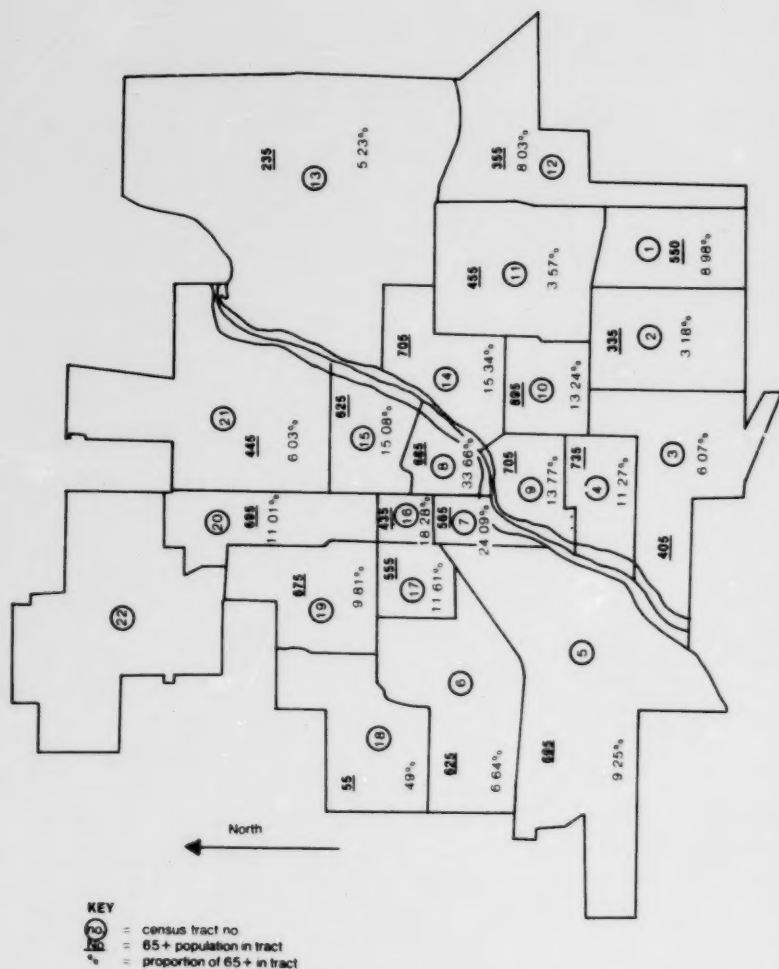
Year	Total Population	Males 65 +	Females 65 +	Total 65 +	% 65 +
SASKATOON					
1956	68,404	3,532	3,214	6,746	9.86
1961	91,478	4,314	4,115	8,429	9.21
1966	111,756	4,514	5,115	9,630	8.62
1971	125,089	4,819	5,945	10,764	8.61
1976	13,5231	5,438	7,267	12,705	9.40
RURAL AREA					
1956	20,051	920	720	1,640	8.18
1961	19,939	992	737	1,729	8.67
1966	19,081	876	777	1,653	8.66
1971	18,519	858	754	1,612	8.70
1976	20,350	903	883	1,786	8.78

Source: S.H.S.P. Covered Population, 1956 to 1976

Figures 2.3 and 2.4 show the distribution of elderly in both the city and the surrounding area. In Saskatoon, the absolute numbers are quite evenly distributed among the census tracts (1971 Statistics Canada data), while the concentration of senior citizens is somewhat higher in the central areas of the city. Some of the seemingly high suburban concentration is due to the location of nursing homes.

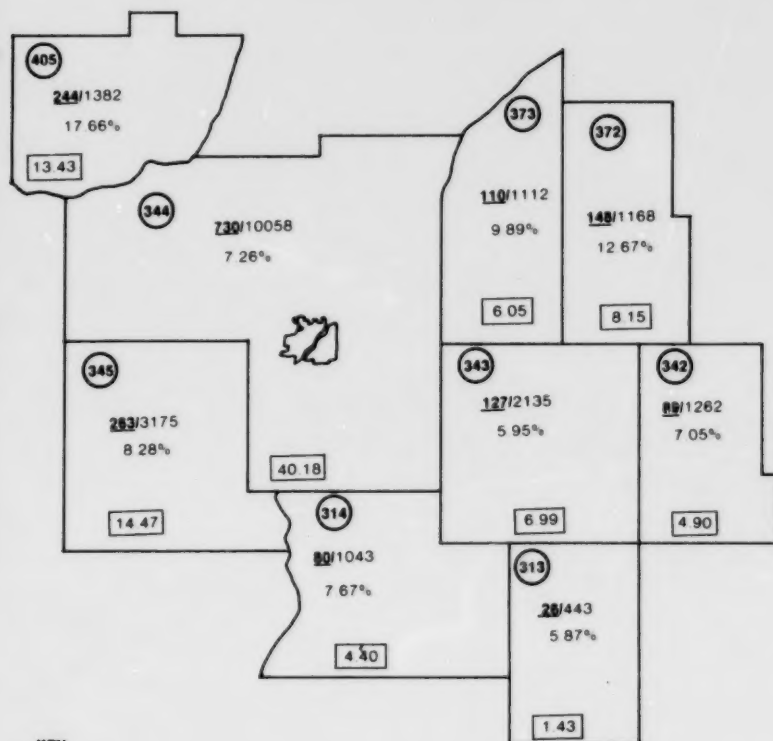
The distribution in the adjacent rural area is reasonably even in terms of proportion of the total population. However, nearly half the rural population and 40% of the elderly are concentrated in RM 344 (Corman Park). None of the other 8 municipalities has as many as 300 senior citizens, and 6 have fewer than 150. The implications of this distribution are discussed in a later section.

Figure 2.3 — Location of Elderly by Census Tract, 1971, Saskatoon.



Source: Statistics Canada, 1971 Census.

Figure 2.4 — Location of Elderly by Rural Municipality, 1977.



Source: S.H.S.P. Covered Population, 1977.

It has been posited that it is more difficult, both physically and administratively, to deliver services to people in isolated locations than to residents of towns and even villages. S.H.S.P. breaks down residence codes into "semi-urban" towns and villages, and more purely rural locations subsumed under a general rural municipality designation. The breakdown of the elderly population in the 9 municipalities in the rural service area is as follows:

Table 2.9 — Distribution of Rural Elderly Population by Town, Village, and R.M., 1977.

Location	No. 65+	% of Total 65+	No. 80+	% of Total 80+
Town	733	40.34	169	50.75
Village	483	26.58	76	22.82
R.M.	601	33.08	88	26.43
TOTAL	1,817	100.00	333	100.00

Source S.H.S.P. Covered Population, 1977

While there is some movement into the towns among the very old, there are still considerable concentrations in smaller centers, and over one-quarter of the 80+ age group remain on farms or in hamlets.

III. HEALTH UTILIZATION CHARACTERISTICS

A. Morbidity and Disability

It is universally acknowledged that morbidity and disability increase with age. However, these two factors have somewhat different significance regarding the health and social service system.

Unfortunately, accurate morbidity data divorced from utilization statistics are not readily available; in fact, the Department of National Health and Welfare was unable to locate general morbidity data for inclusion in the Hon. Marc Lalonde's *New Perspective* white paper. Nevertheless, hospital figures reveal that in 1971, heart disease accounted for 17.3% of all patient days utilized by the elderly, while cerebrovascular disorders accounted for the second largest group of patient days resulting from physical causes. It is important to note that when data for psychiatric hospitals are combined with information from general and allied hospitals, the result is that the single most important cause of hospitalization is mental disorder: 23.1% of all patient days for persons aged 60 and over were attributable to this cause in 1971.²

Ideally, all forms of morbidity should be identified and where possible treated by the appropriate health professional and/or institution. Disease requires intervention, and no doubt the medical resources of society should be as concerned with overcoming morbidity among senior citizens as with curing the rest of the population. Even if there

are no adverse functional effects of morbidity on the elderly, health problems should be carefully diagnosed and treated.

Disability is a somewhat different variable. While it is true that all functional disabilities ultimately result from morbidity, it is not necessarily the case that all morbidity results in functional impairment. It is this functional disability that has the greatest implication for the development of expanded community services such as home care. Therefore, it is important to discover the extent of functional disability among the elderly in order to determine the desirable size of community service programs. A number of studies show that difficulties with the activities of daily living and the concomitant need for community services are extensive.

Drs. Anderson, Brocklehurst, and Hunt have all indicated that a high proportion of those over 80 experience quite profound disabilities; Anderson⁵² has reported that almost 4 in 5 people aged 85 and over suffer from major functional disability. Auerbach²¹ reports that roughly three-quarters of the 65 and over age group suffers from some type of chronic illness. The *Aging in Manitoba* study (1971) estimated that 42% of the elderly required community services. Closer to home, the Prince Albert Region study¹⁰ found that 24% of all senior citizens require at least one service in the community setting, with 37% of the 80 and over category demonstrating such a need. Regardless of different perceptions of need and different survey locations, it is clear that the elderly as a group require a large volume of services if their community needs are to be met adequately, and that existing programs in Saskatchewan are in all likelihood too small to attend to those with significant functional disabilities. This statement is hardly controversial: the Government has announced a province-wide home care program which will greatly increase the amount of money available for community services.

None of this information should obscure the fact that between 75% and 80% of all individuals 65 and over are able to live independently with or without support services.^{28, 29} Dr. Anderson⁵² estimates that only about 1 in 20 require institutionalization, while between 15% and 25% require an extensive program of community health services. From these figures it is evident that not all disability results in a need for support services. It is essential that the total environment of the disabled person be carefully assessed so that services are provided only when absolutely necessary, and never in a fashion destined to promote a loss of functional ability.

B. Utilization Characteristics

For Canada as a whole, the 8.1% of the population who were aged 65 and over in 1971 utilized 35% of all patient days in hospital.²¹ In Saskatchewan, the 10.9% of the population in the same age group in 1976 utilized 41.3% of patient days.¹² In 1971, the average Canadian spent 1.9 days in the hospital, but the average senior citizen spent 8.3 days and those 75 and over spent an average of 12.4 days in

hospital.² As could be expected, the elderly account for a large proportion of hospital patient days, and this trend is roughly uniform throughout the country.

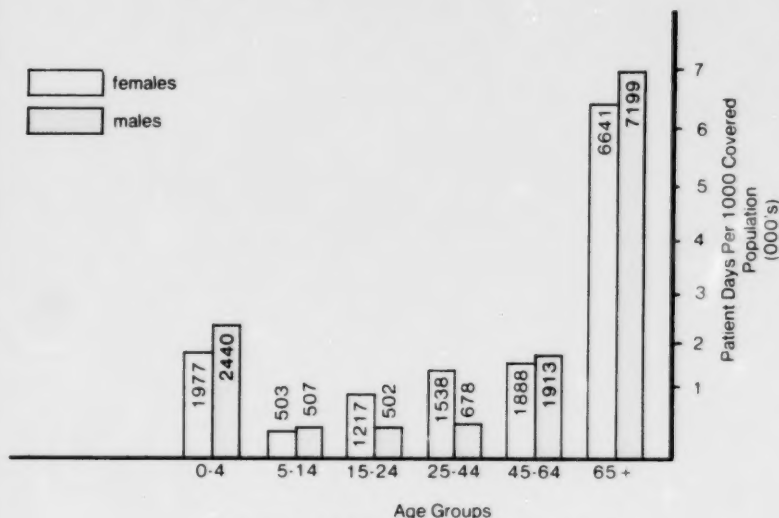
Figures 2.5 to 2.8 show in detail the comparative utilization rates of hospital facilities by the elderly in Saskatchewan. It is noteworthy that while there are considerably more elderly females than males in the province whose average length of stay is somewhat longer in hospital, it is the males who generally are in greater need of hospitalization. While the stereotype of the frail elderly woman may have some validity, it seems that breakdown leading to hospitalization occurs somewhat less frequently than among men.

Dr. Skoll has made some interesting projections of utilization trends by the elderly (see Figures 2.9 and 2.10 below). Both historical and projected figures show a disproportionate use of hospital facilities compared to medical services by senior citizens. This suggests that medical intervention is far more likely to lead to some form of institutionalization among the elderly than among the rest of the population, the implication being that preventive medical services are by and large either unavailable or inapplicable to senior citizens.

Dr. Skoll's projections not unexpectedly show that as more and more people reach 65, more and more health services will be devoted to this age group. By 1985 nearly half the hospital days will be utilized by senior citizens compared to slightly over a third in 1965. While 1 in 6 health dollars went to the elderly in 1965, 1 in 5 was the ratio in 1975 and by 1985 over one-quarter of the provincial health expenditures will be directed toward care of the elderly. This may be viewed from two perspectives. It may mean that senior citizens are becoming more numerous and more sickly, particularly as they increasingly live to ripe old ages; or it may mean that preventive health measures and improved lifestyles among the general population will result in less need for utilization of health services by younger people, with the happy conclusion that one as a rule will not require costly health care until the onset of the unavoidable consequences of aging. Whatever the case, demographic patterns alone are sufficient to warrant increased emphasis on the elderly throughout the health care system.

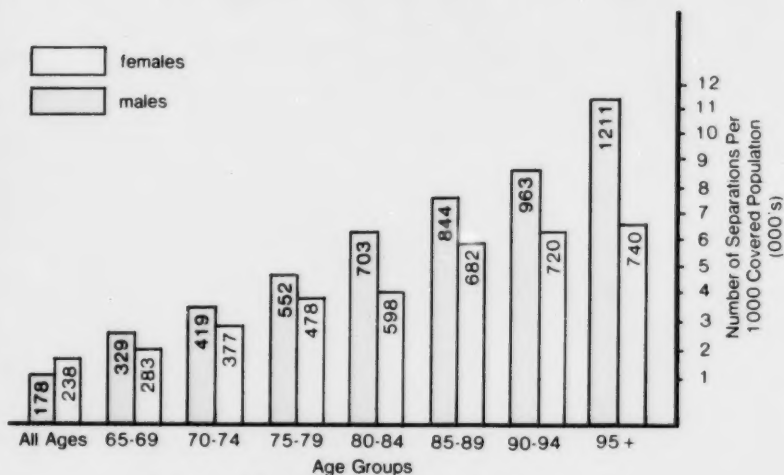
Specific data for Saskatoon and surrounding area combined are not available for the elderly population. However, Saskatoon residents in general have the lowest hospitalization rates in the province: 117 separations per 1,000 population and 1,157 patient days per 1,000 population in 1976, compared to 208 separations and 1,823 patient days per 1,000 respectively among the population (adults and children excluding newborns) as a whole.¹² The figures suggest that Saskatoon, with the most sophisticated facilities in the province at University Hospital and two additional high quality hospitals in the city, serves as a referral center for "difficult" cases throughout at least the northern half of the province, meaning that local population (including the elderly) must "compete" with other provincial residents for beds. As such, it is

Figure 2.5 — Patient Days Per 1000 Covered Population by Age Group, Saskatchewan, 1976.



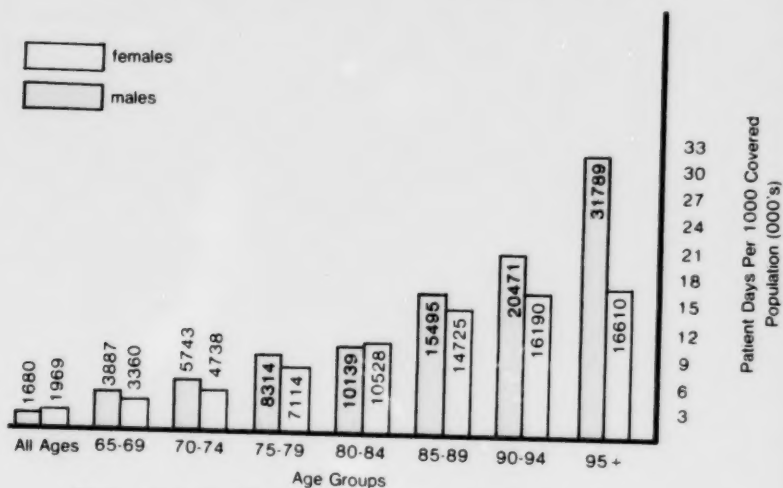
Source: S H S P Annual Report 1976, Appendix C-12

Figure 2.6 — Separations Per 1000 Covered Population by Age Group 65 and Over, Saskatchewan, 1976.



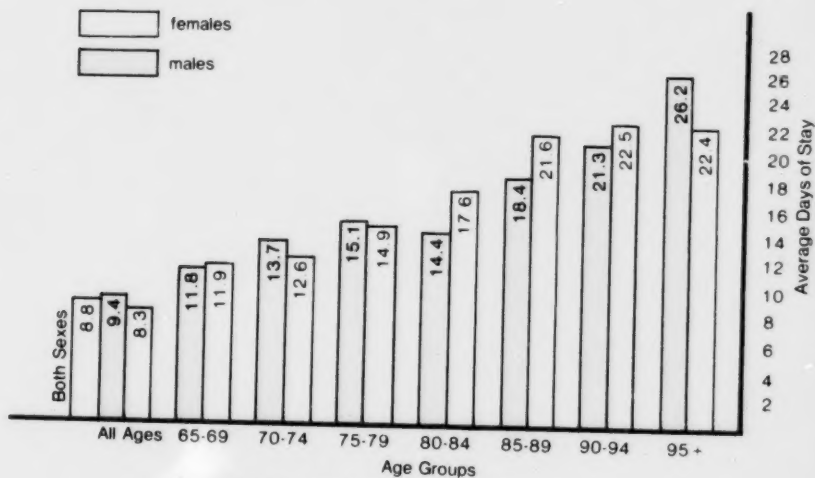
Source: S H S P Annual Report 1976, Appendix C-12

Figure 2.7 — Patient Days Per 1000 Covered Population by Age Group 65 and Over, Saskatchewan, 1976.



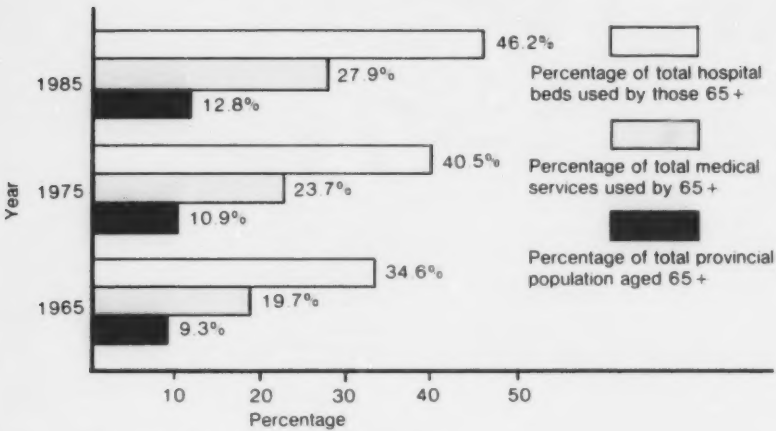
Source: S.H.S.P. Annual Report 1976, Appendix C.12

Figure 2.8 — Average Days of Stay By Age (65 and Over) and Sex, Saskatchewan Covered Population, 1976.



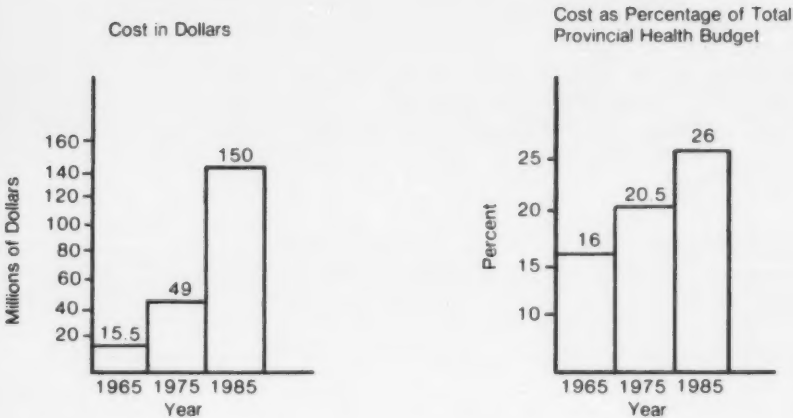
Source: S.H.S.P. Annual Report 1976, Appendix C.12

Figure 2.9 — Trends in the Utilization of Medical and Hospital Services By People Over 65 in Saskatchewan.



Source: Skoll, Dr. S. L. *Adding Life to Years*, 1976, p. 4

Figure 2.10 — Trends in Expenditures on Medical and Hospital Services for Persons Aged 65 and Over in Saskatchewan.



Source: Skoll, Dr. S. L. *Adding Life to Years*, 1976, p. 5

quite probable that residents of Saskatoon receive excellent inpatient treatment, but only when clearly necessary. For the purposes of the geriatric demonstration project, this may mean that Saskatoon's elderly do not often linger in hospital as an alternative to community services or special care home beds.

These impressions have been corroborated by Dr. Hunt, who found that during an eight-week period in June and July of 1977, 99 of 117 individuals 75 and over admitted to University Hospital resided outside the city, and no admissions stemmed from overwhelming breakdown in independent living.²⁷ While very high utilization rates in other (and particularly rural) parts of the province may have rendered the demand for additional community services less urgent, it is unlikely that the same hypothesis could be validated in Saskatoon.

IV. ECONOMIC AND SOCIAL CHARACTERISTICS

A. Income Levels

Table 2.10 illustrates the concentration of senior citizens in the lower income categories.

Table 2.10 — Estimated Income Levels of Senior Citizens in Saskatchewan, August 1976.

Annual Income Range	No. Persons	% of Total
\$ 0-1,500	NIL	NIL
1,500-2,500	1,496	1.5%
2,500-3,000	15,726	15.3
3,000-3,500	38,154	37.1
3,500-4,000	7,601	7.4
SUBTOTAL	62,977	61.3
4,000-4,500	3,331	3.3
4,500-5,000	4,247	4.1
5,000-5,500	2,853	2.6
5,500-6,000	1,694	1.7
6,000-6,500	2,686	2.6
6,500-7,000	1,914	1.9
7,000-7,500	1,974	1.9
7,500-8,000	1,577	1.5
8,000-8,500	1,569	1.5
8,500-9,000	1,386	1.4
9,000-9,500	1,183	1.2
9,500-10,000	1,245	1.2
10,000-10,500	793	0.8
10,500-11,000	867	0.9
11,000-11,500	728	0.7
11,500-12,000	881	0.9
12,000-13,000	1,059	1.0
13,000-14,000	1,201	1.2
14,000-15,000	851	0.8
15,000+	7,525	7.3
TOTAL	102,541	100.0

Source: Saskatchewan Department of Social Services.

Over 3 in 5 senior citizens receive incomes of \$4,000 per year or less, a figure which can be reasonably defined as the poverty level.

Table 2.11 — Income Distribution by Marital Status * for Saskatchewan Senior Citizens (65 +)

Family Income Levels	Single			Married Couples		
	No. of People	% of Single Senior Citizen Population	% of Total Senior Citizen Population	No. of People	% of Married Senior Citizen Population	% of Total Senior Citizen Population
\$Less than 4,000	27,187	59.59	25.74			
\$4,000-4,499	2,512	5.51	2.38			
\$4,500 + ...	15,922	34.90	15.07			
\$ Less than 5,500				1,230	2.05	1.16
\$5,500-5,999				162	.27	0.16
\$6,000-6,499				1,716	2.86	1.62
\$6,500-6,999				14,536	24.22	13.76
\$7,000-7,499				3,844	6.41	3.64
\$7,500-7,999				2,648	4.41	2.50
\$8,000-8,499				1,406	2.34	1.34
\$8,500 + ...				34,466	57.44	32.62
TOTAL	45,621	100.00	43.19	60,008	100.00	56.80

* Single includes widowed, separated and divorced senior citizens

Sources: S.H.S.P., June 1977; 1976 Census; Social Services & Old Age Security

It is evident from Table 2.11 that married senior citizens are better off than single elderly people, especially considering the economies which result from two or more people sharing accommodation. Thus the single elderly may require special attention from financial agencies, and their other service needs are also likely to be greater with increasing age.

B. Marital Status

Census data can be applied only to the city of Saskatoon, rather than to the exact service area covered by this study. Nevertheless, the statistics on marital status are quite striking, with considerable divergencies between the sexes. If one considers that the single elderly are at greater risk than those with companions, then very old women are likely to constitute a group in need of both supervision and direct services.

Table 2.12 — Marital Status of 65+ Population in Saskatoon, by Age Group, 1971.

	Sex	65-69	70-74	75-79	80-84	85-89	90-94	95+	TOTAL	% of Group
Married	M	1,405	895	705	465	170	45	5	3,690	60.20
	F	1,055	665	395	200	95	25	5	2,440	39.80
	T	2,460	1,560	1,100	665	265	70	10	6,130	100.00
Widowed	M	105	115	150	190	165	60	15	800	19.16
	F	675	750	740	660	370	150	30	3,375	80.84
	T	780	865	890	850	535	210	45	4,175	100.00
Divorced	M	25	15	10	10	—	—	—	60	60.00
	F	20	15	5	—	—	—	—	40	40.00
	T	45	30	15	10	—	—	—	100	100.00
Single	M	140	125	120	80	50	20	—	535	56.91
	F	145	95	80	50	20	15	5	405	43.09
	T	285	220	200	130	70	35	5	940	100.00
TOTAL POPULATION: Males — 5,085 (44.82%); Females — 6,260 (55.18%)										

Source: Statistics Canada, 1971 Census

Table 2.13 — Aggregate Marital Status of 65+ Population in Saskatoon, by Sex, 1971.

Marital Status	% of Males	% of Females	% of Total
Married	72.57	38.73	54.03
Widowed	15.73	53.91	36.80
Divorced	1.18	0.96	7.88
Single	10.52	6.40	8.29
TOTAL	100.00	100.00	100.00
TOTAL POPULATION	5,085	6,260	11,345

Source: Statistics Canada, 1971 Census.

The aggregate figures correspond very closely to the national average for all categories.

The figures show that females are much more likely than males to find themselves alone (or at least without a spouse) as they get older. Perhaps a more dramatic illustration of this phenomenon becomes apparent by extracting trends from Table 2.12.

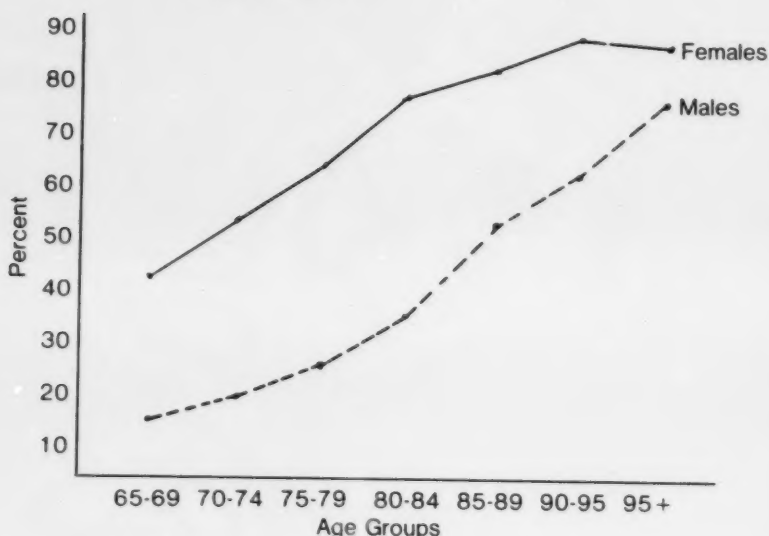
Table 2.14 — Proportion of Elderly Population Single, Widowed, or Divorced, by Age Group and Sex, Saskatoon 1971.

Age Group	Male		Female	
	Number	Percent	Number	Percent
65-69	270	16.10	840	44.33
70-74	255	22.17	860	56.39
75-79	280	28.43	825	67.62
80-84	280	37.50	710	78.02
85-89	215	55.84	390	80.41
90-94	80	64.00	165	86.84
95+	15	75.00	30	85.71
ALL AGES	1,395	27.43	3,820	61.27

Source: Statistics Canada, 1971 Census.

More than twice as many women as men aged 65 and over are without spouses, and almost all women over 80 are either single, widowed, or divorced (with widowhood accounting for the largest proportion of the total). Conversely, relatively few males under 85 are alone — under one-quarter of the total. The figures correspond to the data in Section II above, which show the historical and anticipated excess of very old women over their male counterparts. The trends indicate that the vast majority of women will undergo the traumatic experience of loss of spouse sometime during their senior years, while considerably fewer men will experience this loss. Figure 2.11 further illustrates these characteristics.

Figure 2.11 — Increase in Proportion of Elderly Population Single, Widowed, or Divorced, By Age Group and Sex, Saskatoon 1971.



Source: Data from Table 2.14

C. Housing

The Senior Citizens' Provincial Council has reported that, in 1971, 64% of the province's elderly population were heads of households, with another 19% married to heads.⁶⁷ Of these, 87% resided in single detached or attached houses, while 13% lived in apartments. Fully 81% owned their houses, and only 7.2% reported a mortgage. For this group, then, housing costs very little, and it is fortunate that senior citizens, who generally have low incomes, also are likely to own their place of residence outright, with minimal monthly costs. The low cost of independent housing stands in sharp contrast to the extremely high cost of moving to an institution.

The figures for Saskatoon are somewhat different, reflecting its urban dwelling characteristics. Roughly 69% of the elderly lived in single detached or attached units in 1971, with 31% in apartments. Sixty-six percent of household heads owned their own homes and 13% reported a mortgage. Female household heads comprised 37% of the total compared to 21% in the province overall. Thus somewhat more elderly lived in rental accommodation (meaning constantly increasing costs), and fewer owned their homes outright. Throughout Saskatchewan, senior citizens lived in dwellings about equal in size to the general average, but fewer people occupied these households. These and other data are expanded in Table 2.15.

If it can be assumed that the proportional values of senior citizens' houses compared to all houses in 1971 have remained constant, it is evident that the elderly live in less expensive dwellings which are likely in some disrepair due to old age. Since these houses are for the most part owned outright, grants to refurbish them to allow for continued residence by incapacitated senior citizens might prevent or delay institutionalization, which is characterized by high financial and other costs. Policies should regard independent housing as part of the continuum of locations of care for senior citizens. With this in mind, the suitability of the dwelling for maintaining the health and functional capacity of senior citizens could be paid the same attention as is already the case in special care homes.

Information and analysis of institutional and public/non-profit housing is presented in a separate section on housing policy in Chapter 3.

Table 2.15 — Dwelling Attributes of Senior Citizens Compared to the General Population, Saskatoon 1971.

Population Household Head	Type of Dwelling		Tenure	Average No. of Rooms		Average No. of Bdrms./ Dwelling	Median Value	Reporting a Mortgage	Average Monthly Cash Rent		
	Number	Single Detached		Single Attached	Owned					Rented	
Total Population:											
Male	30,345 (78.6)	21,610 (71.2)	1,951 (6.4)	6,490 (21.4)	19,660 (64.8)	10,685 (35.2)	5.7	2.8	\$17,903	12,230	\$105
Female	8,270 (21.4)	3,995 (48.3)	440 (5.3)	3,855 (46.6)	3,290 (39.8)	4,980 (60.2)	4.5	2.0	13,102	835	92
TOTAL	38,610	25,565 (66.2)	2,390 (6.2)	10,340 (26.8)	22,945 (59.4)	15,665 (40.6)	5.4	2.6	17,230	13,065 (56.9)*	101
65+ Group:											
Male	4,045 (60.6)	2,880 (71.2)	230 (5.7)	935 (23.1)	3,000 (74.2)	1,040 (25.7)	5.2	2.4	13,511	435	89
Female	2,630 (39.4)	1,420 (53.5)	85 (3.2)	1,140 (43.3)	1,405 (53.4)	1,235 (46.6)	4.4	2.0	11,892	145	87
TOTAL	6,680	4,295 (64.3)	310 (4.6)	2,070 (31.1)	4,410 (66.0)	2,270 (34.0)	4.9	2.3	12,978	585 (13.3)*	88

* Percentage calculated from Tenure-Owned category

Source: Statistics Canada, 1971 Census

V. IMPLICATIONS OF DATA FOR PROGRAM DEVELOPMENT

The senior citizen population is growing in both absolute and relative terms. As well, the very old are becoming more numerous at a faster rate than are younger elderly. If current national and especially provincial and local trends continue, geriatrics programs covering a wide spectrum of services in many settings will have to address at least the following matters.

- A. Senior citizens will continue to require an increasing proportion of the health dollar as their numbers and longevity increase. Unless either the rest of society or the elderly themselves experience an improvement in health status leading to reduced demand for services, total expenditures on health will rise even further. This assumes that traditional patterns of curative medicine will prevail.
- B. Costs can be either reduced or held down if preventive theory is translated into practice, especially among the elderly. Contemporary thinking recognizes that early detection and rehabilitation can extend the years of independence for senior citizens. Basic lifestyle revisions can prevent or control potentially crippling disabilities. It is not known, however, how far reaching in effect these preventive measures will prove to be.
- C. It is commonly assumed that the number of Levels 1 and 2 residents can be reduced given the implementation of comprehensive community service programs. What must be acknowledged is that as the number of very old increases, the need for more intensive forms of institutional care will also increase. While in the future it may be hoped that few beds will correspond to current Levels 1 and 2, it can be expected that the demand for Levels 3 and 4 will rise. In the short run, then, the total number of Levels 1 to 4 beds may decline to a degree; in the long run, many Level 1 and 2 beds will be converted to Level 3 or 4 (or their equivalents). The major difference will be that institutionalization will in most cases begin with what is now Level 3; the total cost of institutional care will therefore be higher in the future because all residents will presumably need quite intensive services. It is unrealistic to assume that the total institutional bill will be reduced by the implementation of community based programs or the adoption of better lifestyles. Rather, the rate of increase in these costs will be reduced if the rapid increase in the very old (80-85 and over) population is accompanied by these complementary measures. The saving will be relative, not absolute; but substantial nonetheless.
- D. It appears as if hospital utilization among adults in Saskatoon is well controlled. If this applies to senior citizens, then it is not feasible to expect any decline in patient days among the elderly, particularly as their numbers increase and as their average age rises. National projections show what lies in store for hospital utilization should existing trends continue unabated.

Table 2.16 — Projections of Population and Patient Days in General and Allied Special Hospitals, Canada, 1971-2001

Age Group	1971		1986		2001	
	Population	Patient Days	Population	Patient Days	Population	Patient Days
ALL AGES.....	21,568,300	42,228,300	26,258,600	55,519,200	30,655,500	69,417,000
65 + ...	1,744,400 (8.1%)	14,413,900 (35.0%)	2,565,700 (9.8%)	21,416,000 (38.6%)	3,341,800 (10.9%)	29,512,800 (42.5%)

Source: Auerbach, *op. cit.*, citing Statistics Canada projections.

Clearly, the demand for costly capital projects such as new hospitals and accompanying equipment will increase if these projections are fulfilled. Unless something is done in the near future to alleviate the growth of hospital utilization, pressure to spend limited funds on institutions will grow, and fewer dollars will be available for expanded preventive services. Gradual increases in community service programs may not be sufficient to forestall the demand for more and more beds. The entire issue must be viewed from a longer term perspective so that potential long run savings are not ignored in favor of short term "patch-up" programs and expediciencies. Given the forecast that Saskatchewan's senior citizen population will be proportionally greater and older than any other province's, it is imperative that efforts be undertaken to diminish as far as possible the demand for expensive new facilities.

- E. The most optimistic forecast for success in achieving optimal levels of prevention and reduced need for institutionalization will not obviate the fact that, in the future, relatively more senior citizens in Saskatchewan will be using services supported by relatively fewer taxpayers. In other words, if indeed there will be 20% or so senior citizens in the province in 2031, there will be relatively fewer citizens in the labour force to tax to pay for the services. Thus it will be a monumental achievement if senior citizens can be adequately served without the introduction of much higher tax rates, especially with competition to tax dollars from other sectors such as energy and transportation. The demographic trends leading to this circumstance may result in a revision of thinking concerning compulsory retirement, pension schemes, and so on. At the very least, these patterns mean that new expenditures on geriatrics service programs will have to show their worth in terms of allowing the elderly to live independently for extended periods of time. Such expenditures should therefore be concentrated on the community sector.
- F. Residents of Saskatchewan have come to think that hospital care is almost invariably safe and effective; community alternatives may be viewed as inferior by comparison, to be used only when beds are not available. This philosophy must be overcome if community programs are to be used effectively. It may be necessary, particularly in the next few years, to mount education programs so that people are made aware of the value of community based alternatives. Furthermore, assessment and placement policies will have to be applied rigorously so that no institutionalization takes place unless it is required.
- G. The elderly population will continue to become increasingly female in composition. In 1971 there were 81 males for every hundred females aged 65 and over in Canada. This ratio will decline to 67:100 by 2031, and will be only 37:100 in the 85 and over age category. From this information it can be posited that community service programs should expand in directions aimed at overcoming

functional disabilities more common to females, without, of course, ignoring the needs of the males. For example, the Prince Albert Region survey¹⁰ found that only 11% of females 85 and over are able to shop in winter with no difficulties, and over half this age group cannot do heavy housework at all. On the other hand, preparing a hot meal is less problematic for elderly women, especially compared to the men. By and large, females in the 80 and over group experience significant problems with the major activities of daily living, and this group will grow rapidly in the next few decades.

- H. Different patterns of service delivery may be necessary to account for the lower concentrations of elderly people in the municipalities surrounding Saskatoon. The rural area included within the service boundaries is rather young compared to other rural areas in the province. The population is quite sparse, and many RM's have merely a scattering of very old residents, only a few of whom will need community services. Delivering services to these residents may be more costly because the travel time and expense will necessarily be higher on a per client basis for services delivered in the home. Some rather specialized services may have to be delivered on a somewhat centralized basis, both in the city and in the rural areas, for example day hospital therapy. If this is the case, rural residents will have to travel greater distances than their city counterparts to make use of these facilities. In addition, special transportation arrangements may have to be made to bring senior citizens from outlying areas to service centers. All of this means that while it is desirable to deliver comparable services to all urban and rural residents in need, geographic factors mean that access to some services will involve more effort in some rural areas, and unit costs will be higher outside the city as well.

CHAPTER 3

MEETING THE NEED FOR GERIATRIC SERVICES AND EDUCATION

The Terms of Reference required the Task Force to take an inventory of existing health and social services to determine the precise distribution of resources in the current system. A survey was undertaken from which some valuable information was obtained; however, as has been the experience elsewhere, it proved impossible to assemble a complete dossier because of incomplete survey returns; non-standardized data gathering methods by participants; and unavailability of information in a number of areas. The complete survey results are contained in Appendix 2D.

There are over 40 community agencies and 26 institutions serving senior citizens in the project area. Total health and social service expenditures are roughly \$100 million, a significant proportion of which is spent on residents from outside the project area who look to Saskatoon for specialized services. The vast majority — well over 90% — of this total is spent on institutional services. One third is spent on services to senior citizens.

I. COMMUNITY CARE SERVICES

The Terms of Reference emphasize the development of a community based geriatrics demonstration project; the Task Force fully agrees with this direction. There are two main aspects of community care: prevention, and treatment/service.

Prevention involves education and counselling aimed at effecting lifestyle changes which will prevent or delay the onset of health problems, as well as early intervention where problems have been identified with a view to stabilizing or improving client condition. A number of activities relate to possible preventive effects, including publicity/advertising among high risk groups, and other regular contact with appropriate personnel and programs. Family assessments and counselling by social workers may help prevent serious problems stemming from changing relationships and dependency patterns between the elderly and their families, friends and neighbours. These may be conceived of as indirect services designed to prevent the need for intensive, direct services. As such, preventive services should not be costly and, if effective, they can more than pay for themselves by reducing the need for extensive personal care.

The more extensive and visible component of community programs is actual service delivery. In a sense, even intensive community based service delivery is preventive if it eliminates the need for institutionalization or stabilizes a condition which would otherwise deteriorate. There are several aspects to community care which must be developed in concert for the system to yield maximum benefits.

A. Basic Home Care Services

The Department of Social Services has recognized the need for expanded home care services, involving a core element consisting of nursing, homemaking, meals on wheels, and handyman/repair. These services are delivered in the home, with two main purposes.

Short-term or post-acute home care is designed to shorten hospital stays. In general, clients who can benefit from short-term home care cut across all age groups; services may be quite intensive, but of relatively short duration. The prognosis for the client is in many cases complete cure or rehabilitation. In Saskatoon, this component of home care is quite well developed at the University Hospital Department of Rehabilitation Medicine.

Long-term home care is designed to help primarily older people retain their independence despite the onset of incapacities with respect to the activities of daily living. Although many senior citizens can recover lost functional capacities given appropriate rehabilitation therapy, a significant proportion will need long-term services, with emphasis on the core group envisioned by the Department of Social Services. Long-term home care is a potential alternative to Levels 1 and 2 institutional care if a sufficient range and volume of services are available.

B. Additional Home Care Services

Aside from the basic services outlined above, there are a number of additional elements of a comprehensive home care program which expand its potential for prevention, rehabilitation, and stabilization of serious conditions. Chief among these are physical therapy, occupational therapy, and community psychiatric services.

The University Hospital Home Care program offers physical and occupational therapy services already, but community psychogeriatrics services are not fully developed, although the Psychiatric Home Care program, also operated by the University, has a substantial non-elderly caseload. While the range of services dealing with physical problems appears quite extensive, particularly in the city, at present, the psychological disorders found uniquely among the elderly are not yet completely understood and appropriately treated, especially in the community setting. This area is discussed more fully below.

Institutions have begun to develop outreach programs complementary to basic home care. Sherbrooke Community Centre has opened a day centre to provide therapy and activities for groups of senior citizens from the community, and has planned a large activity centre as well. Such congregate facilities allow for the delivery of group services, with attendant economies and expanded caseloads using a relatively small number of personnel. Day hospitals attached to acute care facilities perform similar functions, but on a somewhat more sophisticated basis. The Provincial Gerontologist, Dr. Skoll, has designed a pilot project in Moose Jaw⁴⁰ to ascertain the potential benefits of day hospitals, with a similar unit possibly slated for

University Hospital. Both of these projects should be closely monitored and evaluated, along with day care centres, and if the benefits prove substantial, additional facilities should be considered given demonstrated need and accessibility to those in greatest need.

C. Foot Care

Foot problems can cause severe mobility problems among the elderly, with considerable loss of independence. Various surveys and experience with foot care programs in Britain have demonstrated that the early identification and treatment of foot disorders can prevent serious problems later in life. Even where prevention is no longer a possibility, careful diagnosis and treatment of foot problems among the elderly can relieve acute discomfort and allowed continued mobility.

It has not yet been proved that the British chiropody system can be adapted to the North American setting to provide comprehensive foot care services. No doubt physicians should be capable of identifying and treating a significant proportion of foot problems. We have not studied the foot care issue in depth, and cannot advocate a specific program design. However, as part of a general effort to increase emphasis on prevention among senior citizens, renewed attention should be given to foot care by the appropriate health professionals, with the goal of reducing mobility loss. In addition, the Government may wish to examine the feasibility of introducing a more comprehensive and specialized foot care program if existing resources are unable to achieve the desired results.

D. Transportation

One of the first effects of the onset of disability among the elderly is loss of mobility, particularly in outlying areas and in winter. Inadequate transportation can result in difficulties getting to and from shopping facilities, friends and relatives, libraries and churches. It can also render some community services based in institutions inaccessible to the very people who most need them.

Solving transportation problems for all groups at reasonable cost is an extremely difficult endeavour. For example, many senior citizens cannot use the bus system; and where alternatives exist, the costs are frequently prohibitive, especially to those in lower income groups. While these problems are serious in Saskatoon, they are even more pressing in the rural area, where the elderly must often travel to the city for services and regular public transit is unavailable or infrequently scheduled.

Door to door service is a must for certain categories of disabled persons (both young and old). If the concept of insuring all services made necessary by health problems is accepted, then subsidized, special transportation should logically become part of the service continuum aimed at promoting client independence. However, the fact remains that a truly comprehensive transit system for the disabled

would be extremely costly, and to our knowledge there is no existing program which operates a service with long hours, quick response to calls, at reasonable cost to both users and the public treasury. While in theory the Task Force supports the development of an extensive, parallel transit system for the elderly and young disabled, we recognize that it would be all too easy to use up an enormous proportion of new funds available for community services in this one area alone. In any event, a proper balance must be struck.

Senior citizens themselves have indicated a need for better transportation, and it should be among the first tasks of a geriatrics program directorate to propose a suitable system in consultation with an appropriate range of ultimate users and current service providers whose programs may be partially or totally adaptable to special circumstances. Both interim and long-term options should be examined; one of the former might include negotiation of a subsidized taxi service in the city, especially during slack periods of taxi utilization. By no means would this be a final solution to a very complex problem, particularly in Saskatchewan where even the urban areas are relatively spread out and the rural areas are sparsely populated. Furthermore, unit costs will inevitably be higher outside the city, and these will have to be borne if there is to be a semblance of equal accessibility to services throughout the elderly population.

E. Psychiatry and the Elderly

The Task Force was made aware of the existence of inadequate psychiatric diagnosis and treatment for senior citizens. Dr. Colin Smith, Consultant, Mental Health Services for the Elderly for the Saskatchewan Department of Health, made several presentations^{41 46} describing the current state of psychogeriatrics, and outlining basic principles governing the proper mental health care of senior citizens. His major points were:

1. Despite the common perception of elderly people as senile and often afflicted with serious psychiatric problems, most symptoms are relatively mild and many conditions are treatable leading to full recovery.
2. Frequently, problems such as confusional states result from undetected physical problems. It is important to treat both physical and mental problems within a holistic framework so that interrelated diagnoses are discovered and treated.
3. A useful approach to diagnosis is the Dynamic Quadruple Assessment, involving analysis of pathological, psychological, and sociological factors, and residual disability.
4. Drugs should be carefully prescribed, as the elderly have reduced tolerance to foreign substances, especially in combination.

5. All forms of stereotypes regarding mental and physical abilities, sexuality, needs and wants among senior citizens should be cast aside in favour of facts and common sense. Like everyone else, the elderly need dignity, money, useful work, intimacy, and good medical services.
6. All medical treatment requires meticulous attention because of the smaller margin for error in the elderly age group and the presence of multiple disorders.

Wasylenki⁸⁵ reports estimates that fewer than 4% of all psychiatric outpatients are 65 and over, and perhaps only 2% of psychiatrists' time in private practice is devoted to the elderly; yet 25% of first admissions to mental hospitals are senior citizens. Incomplete utilization figures for Saskatchewan indicate a somewhat more balanced situation, but the elderly still do not use the psychiatric outpatient system as frequently as younger people, despite the prevalence of more mental disorders.

There is clearly a need for an expanded emphasis on geriatric psychiatry, particularly in the community setting. The Task Force heard conflicting theories of how psychiatric problems are best handled, indicating that the area is not without controversy. For example, there appears to be a strong sentiment among some Saskatchewan psychiatrists against segregating mental patients from others whose problems are purely physical. Dr. Brocklehurst, on the other hand, reported that the two categories are separated in the United Kingdom, an approach he also endorses. Anecdotal evidence suggests that at least some psychiatric cases can severely disrupt programs and environments in special and extended care homes, whereas some mildly confused clients may cause no difficulties in this regard.

The matter of protective services for the elderly has recently received some attention in a number of jurisdictions. Protective services involve safeguarding clients whose mental competence to handle legal and financial affairs may be in question from potential abuse and neglect. In a more preventive aspect, protective services may involve intervention designed to deal with problems before they become serious enough to warrant the formal delegation of decision making authority to others on behalf of the client. While we have not examined the issue of protective services in detail, we wish to draw it to the attention of Government so that any statutory or regulatory provisions dealing with delegation of authority to a client's representative do not overly restrict client participation in his own affairs or subject him to possible exploitation.

The Task Force cannot recommend definitive prescriptions for overcoming all of the shortcomings in the field of psychogeriatrics. However, steps must be taken to rectify what is universally viewed as an unacceptable situation. Preliminary measures might include:

1. The encouragement of interest in mental health services for the elderly among residents in psychiatry.
2. The development of continuing education courses available to a wide spectrum of health workers aimed at dissolving prevalent misconceptions about mental health and the elderly.
3. The development of seminars for physicians to encourage more accurate diagnosis and treatment of uniquely geriatric problems; greater awareness of drug reactions and side effects peculiar to senior citizens; and better understanding of the relationship between physical and mental problems and potential for recovery.
4. The review of services available to the elderly by the Psychiatric Services Branch, in light of conflicting approaches and opinions; and the establishment of standards for inpatient care of senior citizens with mental disorders so that clients who could have a detrimental effect on others are segregated if necessary, while others whose mental problems are non-disruptive can be integrated into the normal institutional and rehabilitative stream wherever possible.

F. Recommendations

1. *Both short-term and long-term home care should be expanded to reach their optimum preventive and rehabilitative potential, in line with basic Provincial Government policy guidelines and with initial emphasis on the core services including homemaking, nursing, meals on wheels, and handyman/repair.*
2. *Physical therapy, occupational therapy, and community psychiatric services should be developed to deliver maximum benefits to the elderly, with particular emphasis on rehabilitation and the retention or recovery of independence in all possible instances.*
3. *Special and extended care homes should develop day centers and activity centers in response to identified needs so that services such as physical and occupational therapy and meals can be delivered on a group basis with maximum economic efficiency and effective deployment of staff.*
4. *Acute care facilities should develop day hospitals following demonstration of the utility and efficiency of the Moose Jaw, and perhaps University Hospital pilot projects, for the purpose of providing a sophisticated range of services to senior citizens on an outpatient basis.*
5. *The appropriate health professionals should pay renewed attention to the issue of foot care so that problems which may lead to loss of mobility among senior citizens can be detected and treated as soon as possible, and measures can be taken to reduce the discomfort resulting from problems too advanced for preventive intervention.*

6. *The Geriatrics Program Directorate should plan a transportation system accessible to incapacitated senior citizens and the young disabled, in consultation with the appropriate agencies and potential users, taking into consideration the role of transportation in the continuum of community oriented services; interim options designed to alleviate the most pressing problems; and a long-range master plan developed in coordination with existing transit facilities, with a view to keeping both client and publicly borne costs at a reasonable level.*
7. *The entire field of psychogeriatrics should be emphasized to achieve the elimination of stereotypes surrounding mental health and the elderly; the encouragement of more intensive non-institutional diagnosis and treatment of mental disorders; the review of current services available to the elderly by the Psychiatric Services Branch of the Department of Health in view of conflicting approaches to treatment; the establishment of standards for both the integration and segregation of psychiatric patients, depending on the likelihood of disruptive effects on other patients, programs, and environments. A review of protective services and practices should accompany this effort.*

II. HOUSING

If there is to be a fully integrated system of care, suitable housing must exist, with policies designed to enhance potential for independent living in the community among senior citizens. The effects of good housing policies apply to both existing, independent dwellings in the community, and public housing projects.

A. Independent Dwellings

Senior citizens typically live in, and own outright, their own homes, which are marginally smaller and considerably older than those inhabited by younger people. The consequence is that while independent housing is rather inexpensive for many senior citizens, the homes may be in some disrepair, and in need of modification if they are to be suitable residences for significantly incapacitated people.

The province began a Senior Citizens Home Repair program in 1973 which now provides a once in a lifetime grant of up to \$650. By 1976, the program had largely outlived its usefulness, as most of those eligible for grants had already received them. The average grant during the first four years of the program was roughly \$325, which is hardly sufficient to make substantial modifications in housing to accommodate incapacities, let alone major structural repairs.⁶⁸

Central Mortgage and Housing Corporation finances a Residential Rehabilitation Assistance Program (RRAP) to provide loans of up to \$10,000 for major projects, some of which may be forgivable; the program extends to all citizens regardless of age. While the program theoretically meets the need for major funding of major alterations,

senior citizens are not likely to make use of the program given low incomes and the necessity of assuming another mortgage.

Neither of these programs has been designed to incorporate independent housing into the general continuum of services and residential facilities available to the elderly, with an emphasis on independence. As a result, whatever benefits have accrued from the programs have apparently not alleviated the demand for institutional beds, nor have increased home care services been planned and delivered in conjunction with measures to improve the suitability of housing for care of the elderly.

If expenditures on independent housing stock are seen in the context of promoting independent living and reducing the demand for costly institutionalization, the development of new, more substantial programs may well appear economical in the long run. For example, the cost of one year of Level 3 care is approaching \$11,000; if an \$11,000 household modification grant could prevent or delay institutionalization for a single year, the grant would have been justified, especially as the elderly population increases dramatically and the demand for more beds grows. The modified house would presumably be both more valuable, and suitable for accommodating other incapacitated people in the future. If desirable, policies could include provisions for returning to the public treasury that part of the ultimate sale price attributable to the modification grant.

The Saskatchewan Housing Corporation, the Department of Social Services, and the Department of Health should jointly develop and publicize a housing policy pertaining to independent dwellings, within the framework of an integrated system of care emphasizing community services for the elderly, and assessing both short-term and long-term costs and benefits of various alternatives. The policy should take into account demographic patterns and new developments in technology which may allow continued independence for increasingly incapacitated people, particularly given the expansion of support services. At least one goal of a revised housing policy should be to help eliminate the need for Levels 1 and 2 institutional care (see Sec. III. below for elaboration).

B. Public Housing

For largely financial reasons, current public housing policies are mainly determined outside the province by Central Mortgage and Housing Corporation and National Housing Act regulations. The result has been that unit costs have been the major factors in determining design specifications, admissions criteria, and capabilities for accommodating disabled persons.

Traditionally, Saskatchewan has used Section 40 of the National Housing Act (N.H.A.) for financing public projects for the elderly. The section is attractive because costs are apportioned as follows: 75% is paid by Ottawa, 20% by the province, and 5% by local interests.

However, design specifications are rigid. Built-in features facilitating the housing and care of the disabled are perceived as expensive, and therefore, luxuries. As a result, public housing in the province, and certainly in the project area, has for the most part served fully ambulatory, low income senior citizens. Provincial studies^{65,76} have shown that Local Housing Authorities (bodies responsible for developing public housing in their areas) by and large do not view accommodating persons with special care needs as part of their mandate; hence there has been a firm distinction between "shelter" and "care" instead of an integration of the two components.

There are other sections in the N.H.A., for example Section 43, which permit more flexibility in design and concept because provincial financial participation is increased. Saskatchewan has lagged behind some other provinces in resorting to other sections, although current federal policy strongly encourages the abandonment of Section 40. In the context of the entire housing and institutional spectrum, the result has been that institutional beds have proliferated even during the most active periods of construction of public housing, with a concomitant need for extensive subsidies.

The traditional provincial financial policy has been to subsidize units, rather than residents. This means that the province agrees to pay the difference between full mortgage and operational costs and designated rents geared to low income senior citizens. Income is therefore the major criterion for eligibility for public housing; incapacity has not up to now been a prominent consideration. This restriction has meant that the province is locked into higher annual subsidy levels each time a new unit is completed.

If one of the goals of senior citizens' public housing is to limit the demand for institutional care, especially as the very old become more numerous during the next twenty to sixty years, policies will have to be revised, and existing projects may have to be modified. The preventive and care aspects of public housing integrated into the continuum of services available to the incapacitated would include at least the following:

1. Access ramps, hallways, kitchens, doorways, and bathrooms suitable for wheelchair clients, including suitable sinks, stoves, toilets, etc.
2. Grab bars and railings in all areas such as hallways, bathtubs, etc. where accidents due to infirmity are possible without supports.
3. Resident supervisors, connected to each unit by electronic notification systems, automatic warning systems (e.g. if the toilet is not flushed for 24 hours, a light goes on at a central switchboard), etc., who look out for possible problems and initiate emergency procedures when necessary.

4. Provision for community care program offices on the main floor of larger projects as an added safety and care measure.
5. Provision of extensive home care services to clients in public housing, who should be admitted at least partially on the basis of need for this kind of care.
6. Formal liaisons with special care homes (which in the future should begin at what is now Level 3 care) so that there can be movement back and forth along the continuum of care in response to improvements or deterioration in condition.
7. Provision of admission of relatively prosperous clients, able to pay full, unsubsidized rents, whose purpose in moving to public housing is to take advantage of the safety and care features.

Implementation of these concepts is long overdue. Sheltered housing has been in existence in Britain and the Scandinavian countries for years, and the previously cited provincial studies have all come to the same general conclusions. However, it is acknowledged that changing long established policies and regulations, particularly where the two senior government levels are involved, may take time. In the Saskatoon area, the number of senior citizen units has expanded considerably during the past five years, to the point where it is possible that sufficient units exist to meet *needs* (as opposed to demand), given a new understanding of the purposes of both independent housing and special care home beds. The Saskatchewan Housing Corporation and Local Housing Authority should jointly re-examine policies in light of new directions in shelter and care, with a view to incorporating housing into the overall continuum of services and expanding its preventive and service potential. No new projects should be approved without due consideration of design alternatives promoting the desired policies.

C. **Recommendations**

8. *Independent housing stock should be conceived as part of the continuum of facilities suitable for care of the incapacitated elderly, and policies should be developed in the context of a shift in the focus of care from the institutional to the community sector.*
9. *All existing funding programs for senior citizens' household modification and repair should be reviewed jointly by the Saskatchewan Housing Corporation, the Department of Health, and the Department of Social Services to assess their role in promoting independence and their effect on the demand for institutionalization; and if necessary, a new independent housing policy should be developed with funding provisions taking into account the benefits of improving existing stock, and the potential of an expanded program for reducing the need for costly institutional care.*
10. *The province should establish a policy whereby public housing is*

considered an integral component in the care system, with the potential for replacing Levels 1 and 2 facilities.

- 11. The province should make use of those sections of the National Housing Act which allow for appropriate flexibility in design and funding of features to accommodate the incapacitated, in line with a general policy of reorienting public housing as a locus of moderate to intensive community care.*
- 12. The province should endorse the concept of sheltered housing, with funding for resident supervisors; electronic communications features for purposes of routine and discreet supervision and emergency calls; design of access ramps, hallways, kitchens and bathrooms to accommodate significantly disabled persons; and community care program offices on the main floor as added safety and care provision.*
- 13. Admissions criteria should be established according to which the need for community services and availability and cost of alternatives are given considerable weight, with secondary emphasis on ability to pay; and waiting lists should be coordinated with the priorities criteria established throughout the community and institutional service system.*
- 14. There should be formal liaisons between institutional facilities (primary Level 3) and public housing projects to facilitate movement back and forth along the continuum of care in response to improvements or deterioration in condition.*

III. SPECIAL AND EXTENDED CARE FACILITIES (LEVELS 1-4)

The demographic information contained in Chapter 2 and the service inventory survey reveal two important characteristics: first, there will be a startling increase in the number of very old citizens of Saskatchewan during the next quarter to half century, most of whom will be women and many of whom will be severely disabled; and second, there is currently a high rate of institutionalization among senior citizens which if applied to projected population trends, will necessitate enormously increased expenditures on capital projects and ongoing subsidization of care.

Given these trends, it would be unrealistic to aim at an absolute decrease in the total number of institutional beds in the long run, even with a significant shift in the location of care to the community setting. Rather, the most promising prospect is to eliminate the lower levels of care from the institutional sector so that, ultimately, Levels 1 and 2 beds and facilities are converted either to Levels 3 and 4 for occupancy by more seriously disabled residents, or other purposes. The British and Scandinavian systems of care strongly suggest that our Levels 1 and 2, involving 20 and 45 minutes of supervisory care per

day, are obsolete institutional categories. Yet over 600 people in the project area (excluding the young retarded) live in Levels 1 and 2 facilities, mainly for want of appropriate community alternatives.

Although it is highly desirable to eliminate Levels 1 and 2 care from institutions, the process cannot take place over night, nor in a vacuum. It is unlikely that many currently institutionalized clients would be able to return to the community setting in the foreseeable future, although some "reverse movement" might be possible if a concentrated effort is made. Environmental factors make movement often traumatic and in most cases unsatisfactory. Instead, beds will become vacant through attrition of current clientele due to death or movement to higher levels of care, rather than wholesale evacuation of homes.

An expanded community service network, including a revised housing policy, must be in place before any short-term reduction in demand for Levels 1 and 2 beds is achieved. Thus new expenditures in the community sector will bear fruit only after a certain period of time — perhaps 5 to 10 years — during which new programs achieve legitimacy and waiting lists disappear. The decrease in the number of minimally incapacitated institutionalized elderly will occur gradually. The optimum results will be twofold: first, a reduction in the need for special care home beds; and second, an improvement in the quality of life for the elderly under the assumption that independence in the community setting is preferable to institutionalization.

Short run problems arising out of new policies and emphases must be dealt with. Level 1 care is not directly subsidized at all on a per bed basis (although residents receive Saskatchewan Assistance Plan benefits if eligible). Level 2 beds are subsidized at the rate of \$144 per month, which is 20% to 25% of the total cost. Clearly, the prospect of empty beds means considerable loss of revenue for special care home operators, although presumably staff cuts would accompany caseload attrition. The fact remains that some form of financial provisions for conversion of vacant beds to other purposes should be built into general policies so that outstanding mortgages can be paid despite partial occupancy, and during the renovation phase. Although not all Level 1 and 2 beds will be convertible to Levels 3 and particularly Level 4, the anticipated need for day centers, activity centers, and sheltered housing should easily find use for sound physical structures. The important point is that expenses incurred during the short run should be viewed in the context of the ultimate reshaping of institutional philosophy and care.

After a period of several years, the long-term institutional sector will consist of what are now Levels 3 and 4 care. The revised sector should house approximately 5% of the senior citizens in the catchment area (which extends beyond the project boundaries and includes an estimated 20,000 elderly). Furthermore, all of the illogical classification and funding anomalies characteristic of the current system should be eliminated (see Chapters 4 and 5 for elaboration of organizational and

financial problems and proposed solutions). Among policies which should be instituted are:

1. There should be a single, institutional classification, although the program emphasis in different facilities may reflect different kinds of clientele with different conditions and prognoses.
2. The health component of services should be fully insured, with a flat rate room and board charge for those able to pay.
3. Facilities should be encouraged to provide a broad spectrum of care and services so that movement between institutions is kept to a minimum. This implies a minimum sized facility, which may be difficult to justify in the rural areas. In some cases, based on local preferences, smaller homes may continue to exist with reduced programming which is, however, acceptable to clients and community residents.
4. Formal liaisons should be established with newly conceived public housing projects so that movement back and forth along the continuum of care is possible.
5. Responsiveness to changes in client needs requires empty beds. The concept of distinguishing beds set up from rated bed capacity, with appropriate funding, should be thoroughly examined, with a view to providing flexibility in the admissions system geared to client needs and emergency situations.
6. As soon as procedures are developed, all admissions to Levels 1 to 4 institutions should be approved through the District Assessment Unit. This will facilitate the reduction in demand for Levels 1 and 2 care, the duplication in waiting lists and time spent in completing application forms, and the admission of priority clients on the basis of need.

These basic features should be part of a master plan for the project area to be conceived in consultation with representatives of the components of the care continuum, and the public. Piecemeal changes should be avoided in favour of developing a definitive set of goals before moving to measures aimed at achieving them. Especially when physical facilities are involved, errors are often irreversible. A long-term view must be taken so that ultimately, institutionalization will be the alternative only for those who need it, and will promote the rehabilitation or stabilization of clients with serious incapacities. In no instance should it be used as a convenience when independent alternatives exist.

Recommendations

15. *Levels 1 and 2 care in institutions should ultimately be eliminated, given the expansion of community care programs and revised housing policies.*

16. *Institutionalization should begin with what is now Level 3 care in the long run, and all institutionalization should fall under a single classification category with rationalized delivery of service and funding structures.*
17. *A target of 5% institutionalization among the elderly should be set for the project area, involving 1,000 beds, the decrease resulting from attrition among Levels 1 and 2, but given demographic trends, a master plan should be developed for adding new beds suitable for Levels 3 and 4 through conversion of existing facilities.*
18. *Facilities should be encouraged to provide a suitable range of services to look after the health and environmental needs of their clientele, with minimal movement between institutions.*
19. *At least two institutions offering Level 3 and 4 care should be funded for designating a total of 8 to 10 beds as "flexibeds" to accommodate urgent needs immediately.*
20. *In the long run, all institutions should provide vacation beds for use by clients on a short-term basis while their families or other sources of care are temporarily absent.*

IV. PRIVATE SPECIAL CARE HOMES

A. Discussion

There are over 100 private special care homes in Saskatoon providing from minimal to Level 4 care to over 300 residents. There are from 1 to 15 beds in each home. Many facilities are not formally approved by appropriate authorities. The Task Force heard that there does not appear to be a single authority actively responsible for defining standards, monitoring care provided, and enforcing regulations. While both the City Health Department and the provincial Departments of Health and Social Services have some jurisdiction in this area, there is evidently no clear agreement on which body should perform these functions. The result is that there is a virtually unmonitored network of homes providing care.

There is as yet no concrete evidence as to the nature and quality of care provided, and the Task Force has no conclusions in this regard. However, the major concern of the community is to integrate the private special care homes with the rest of the system, including assessment, funding, monitoring, and evaluation.

B. Recommendations

21. *There should be a single authority responsible for defining standards, monitoring care, and enforcing regulations pertaining to private special care homes.*
22. *Policies regarding client assessment and placement, short-and long-term funding and subsidization, and program monitoring and*

evaluation should apply to private special care homes as well as other components of the community and institutional system of care.

23. *The possibility of establishing formal affiliations between private and larger special care homes should be explored.*

V. ACUTE CARE HOSPITALS

There are 1,241 beds (rated capacity) in the project area, in the three Saskatoon Hospitals and Borden Union Hospital (10 beds). The data from Chapter 2 reveal that district residents are relatively sparing users of hospital services. Except in certain circumstances, senior citizen utilization rates cannot be expected to decline appreciably as a result of implementing new community programs. In fact, utilization by the elderly will increase as the population becomes older.

A. Patterns of Care

Because of the nature of admissions to hospital, it is difficult to evaluate the appropriateness and effectiveness of inpatient care. However, we do not wish to exempt hospitals from the general criticism that there appears to be no integrated system of care designed to place senior citizens in the appropriate programs and facilities. The lack of coordination among hospitals and special care homes frequently results in long and inappropriate stays in acute care facilities. Similarly, anecdotal evidence indicates that there is no rational system for diagnosing the peculiar conditions of the elderly or admitting clients on a logical priority basis. These deficiencies are not peculiar to the project area, but are very probably prevalent throughout the country.

As a part of a general effort to identify and treat the problems of the elderly more precisely, hospitals and staff should develop programs and strategies for dealing with geriatric problems and carrying out thorough assessment and treatment programs as efficiently as possible. It is especially important to eliminate unnecessary lingering resulting from inadequate diagnostic attention and unavailability of more appropriate resources elsewhere.

B. The Geriatric Assessment Unit

University Hospital has proposed an 18-bed Geriatric Assessment Unit (GAU) designed to carry out thorough and accurate diagnoses of the unique problems encountered by the elderly. The unit, if developed as proposed, would also have an outpatient aspect.

The concept of the GAU has been proved successful in England; however, our system of medical care is somewhat different, and it remains to be seen whether the British model is successfully adaptable to Canada. Nevertheless, we view the GAU as a potentially valuable addition to services available to the elderly. The unit will no doubt serve as the clinical adjunct to the academic aspect of the Division of Geriatric

Medicine at the University of Saskatchewan. While we appreciate the need to provide a wide range of clinical experiences for educational purposes, we emphasize that our main concern is that the GAU meet the service needs of the community as efficiently and as democratically as possible.

When fully operational, the GAU should fulfill the following functions:

1. The inpatient diagnosis of senior citizens whose problems are difficult to identify accurately, who have multiple problems whose combined effects are difficult to assess and treat, and who require a multidisciplinary assessment over time to ascertain the complete physical, mental, and environmental profile.
2. The assessment of all prospective admissions to Level 4 facilities, provided that referrals to the unit can be effected quickly by a suitable cadre of physicians and their associates.
3. The assessment of clients for day hospital treatment and perhaps other care if these other facilities are available.

C. Recommendations

24. *Hospitals and staff should develop plans to rationalize the admissions criteria and to improve the accuracy of diagnostic and treatment services to senior citizens as part of a general effort to increase the emphasis of geriatric medicine.*
25. *The Geriatric Assessment Unit at University Hospital, if approved, should be closely monitored and evaluated to ensure that it is able to carry out assessments for prospective Level 4 clients; provide intensive diagnostic services to community residents on a rationalized admissions basis; and provide access to a suitable range of community physicians on a direct or indirect basis.*

VI. SERVICES IN THE RURAL AREAS

As the inventory survey reveals (see Appendix 2D), there are a number of institutional and community based programs outside Saskatoon in the project area. It is notable, however, that the southeast area looks almost exclusively to Saskatoon for provision of health and social services, with little local development of programs.

It is fully our intention to ensure that services are available to the rural residents of the District on a comparable basis with their city counterparts. Yet problems may arise as services become increasingly sophisticated in response to the special needs of smaller groups of people. Coupled with the transportation and cost questions, the matter of the decentralization of services to small communities becomes somewhat problematic. It is essential that principles be enunciated on the basis of which rational decisions can be made concerning the provision of services centrally in Saskatoon, or locally.

A. Accessibility

Certain services and facilities are feasible only where sufficient concentrations of elderly people exist to operate them economically. Day hospitals, assessment units in acute care hospitals, and day centers are examples.

It has been recommended that these services be made available to senior citizens throughout the project area. The district has a radius of roughly 30 miles around Saskatoon, which is a not inconsiderable distance to travel, especially for the elderly and if regularly scheduled public transit is unavailable. There are three alternatives to the accessibility dilemma surrounding certain kinds of services.

1. All services other than those requiring sophisticated hospital equipment for diagnostic purposes could be decentralized to the towns and perhaps villages in the area, despite the diseconomies involved. This would ensure maximum local accessibility to elderly residents, and would overcome the transportation problems to a considerable extent. The main drawback would be sometimes prohibitive costs given very small caseloads and inefficient use of highly trained personnel, if the latter are indeed available.
2. All services more economically centered in Saskatoon could be offered within the city. An extensive transportation system could be developed to bring elderly residents in from the surrounding area to make use of these services. The transportation costs would be add-ons to the system, but service costs would be kept down and availability of personnel would not be a problem.
3. Criteria could be developed for determining the feasibility of locating staff and services in outlying areas on a permanent basis. For example, it could be assumed that any services which could be delivered on a per unit cost basis of 20% higher than in Saskatoon would merit delivery in the rural areas. More inefficient economic consequences would mean that the services would have to be delivered in Saskatoon, unless it were feasible to locate staff in the city who would travel to area centers on a regular basis to provide services.

The problem is not easy to solve, although the third alternative appears to be the best compromise. If permanent staff and facilities are not justifiable in the outlying centers, every effort must be made to send services out from Saskatoon on a regular basis, for the advantages of being able to make use of services locally are considerable and worth spending a reasonable extra amount. Services which can only be available in Saskatoon must be accessible to the rural elderly, implying a need for a functional and imaginative transportation system (as already recommended). The major factor to be remembered is that unit costs may have to be higher in the outlying areas, and these costs should be borne ungrudgingly. It is provincial policy to maintain the viability of rural communities, and included in this worthwhile endeavour

is a need to ensure that a reasonable range of services is available as conveniently as possible.

Happily, it appears as if three of the basic home care services — homemaking, handyman/repair, and meals on wheels — have been successfully provided to the elderly in the rural areas; nursing is more problematic, but given expanded caseloads, this, too, should be feasible on a decentralized basis. The major preventive services ought to be able to locate in the rural centers, and this in time should prove to be a significant and highly beneficial achievement.

Table 3.1 suggests possible locations for service delivery depending on place of client residence (see page 93).

B. Recommendations

26. *The basic home care services of homemaking, nursing, meals on wheels, and handyman/repair should be delivered locally in the rural areas.*
27. *Other services should be delivered on a decentralized basis to the rural areas provided that there is sufficient demand, and unit costs do not unreasonably exceed the alternative cost of providing the services in Saskatoon.*
28. *Where services are provided centrally in Saskatoon, provision must be made for adequate transportation of rural residents to and from the city to maintain reasonable accessibility to facilities.*

VII. SERVICE VOLUMES

A. Home Care

It is currently estimated that about 400 clients receive home care at any given time in the district,⁹ excluding psychiatric home care. The figure may be somewhat imprecise because of problems of definition, double counting of cases by agencies, and missed cases; however, data from the major organizations involved in home care suggest that the order of magnitude is correct.

There is no precise indication of the volume of home care services required in the district, based on a comprehensive survey of need related to fully developed service standards and admissions criteria. Previous surveys indicate that there is likely considerable unmet need among the elderly. The Prince Albert study estimated that 24% of the elderly have at least one unmet service need in the community, implying a caseload of roughly 3,000 annually; the 1971 *Aging in Manitoba* study put the figure at 42%, which would mean nearly 6,000 cases in the district aged 65 and over.

The ultimate appropriate caseload will depend on program design and criteria. It may be instructive, however, to examine the experience in Manitoba, which has developed a comprehensive home care program over the past four years. The initial goal in that province was to

provide 1.35% of the population with home care after two years; this translates to a total caseload of 14,000, three quarters of whom would be senior citizens. However, by 1977, the average caseload for the province appeared to have levelled off at between 8,000 and 9,000 following previous rapid expansion, meaning perhaps that outstanding needs are less prevalent and serious than anticipated.

As our service district is largely urban, it is perhaps more appropriate to relate Winnipeg statistics to projected needs. The Winnipeg caseload has levelled off at somewhat over 5,000; adjusting for population, a comparable figure for Saskatoon would be around 1,300 of whom over 900 would be senior citizens. Given turnover of clientele, about 2,500 discrete cases would be served annually, including short-term, post acute care clients.

About 45% of Winnipeg clients require nursing; 34% homemaking; 7-8% auxiliary services; and 4-6% therapy. While one must be cautious in applying external data to a newly expanding local program, it would appear that major expenditures should be allocated to the basic services outlined in provincial policy.

The Manitoba program has a total budget of roughly \$8 million, which is well below the planned \$11 million program in Saskatchewan. However, the Manitoba program uses some staff and facilities for which it does not directly pay. Comparable caseloads would certainly not appear excessively large; in the next three years, the program in the Saskatoon district should be capable of handling an average caseload of 1,300, based on demonstrated needs according to well developed assessment and service criteria. No far reaching service expansion should be contemplated until proper assessment procedures have been developed and found accurate.

Day hospitals and day centers will in the future become important components of home care, or more accurately total community care. Until demonstration projects prove their worth, it will be difficult to assess the need for these services. Day centers attached to special care homes will no doubt be the foci for therapy services to community residents, and the Sherbrooke model should be evaluated and emulated if successful. Because day centers must be easily accessible to achieve maximum benefits in the community, it is not inconceivable that 2 such facilities could be warranted in Saskatoon, serving an average caseload of 100 senior citizens. Therapists could travel to centers in the rural area on a scheduled basis in a fully equipped mobile unit to provide these services, given sufficient demand and the suitability of physical facilities; alternatively, rural residents could be brought to Saskatoon.

The volumes do not include community psychiatric services, which we regard as distinct from what are normally thought of as home care. While we fully support the improvement of mental health services for the elderly, we cannot ascertain funding needs at this time. In any

event, new funds should come from sources other than the home care grants.

B. Housing

There are over 900 public housing units for senior citizens in the project area, or 60 per thousand. British authorities, notably Sir Ferguson Anderson, estimate that 50 sheltered housing units per thousand elderly are sufficient. Anderson assumes the existence of the British health and housing system, however, and our units are not comparable to sheltered housing in Europe. Thus it is difficult to assess accurately the need for sheltered housing in Saskatchewan given a reorientation of design and admissions criteria.

If new housing policies are implemented, it would seem reasonable to develop a plan for modifying existing public housing units, especially in the city, to conform to the sheltered housing concept over time, on the assumption that perhaps sufficient units already exist. On the other hand, if it is seen as desirable to provide two types of public housing — sheltered housing with an extensive supervision and care component, and independent units with low rents for fully capacitated people — new projects may be considered. In either case, there is without doubt a shortage of housing capable of preventing admission to Levels 1 and 2 institutions. Policies should be developed to increase the number of units accessible to significantly incapacitated people in order to eliminate the need for Levels 1 and 2 as the only alternatives for many senior citizens. A long range goal of 750 such units for both the elderly and the younger handicapped is not unreasonable given the large number of Levels 1 and 2 beds now in existence. As least some of these units should be in rural centers, given sufficient demand. However, projects will have to be smaller, with attendant diseconomies of scale; while to a certain degree these are acceptable, there should be close coordination between community care services and housing projects to ensure maximum availability of services at reasonable costs.

C. Institutional Facilities

The long run goal should be to reduce the number of institutionalized senior citizens to 5%; assuming that the project area serves 20,000 elderly in this regard, this translates to 1,000 beds. All of these beds should conform to what are currently Levels 3 and 4 care.

While there should ultimately be no rigid categorization of clients based on financial criteria and dubious differences in amount of care required, there will be some variance in program needs and overall circumstance. Based on currently perceived needs, there appears to be a greater need for Level 4 programming, while the demand for Level 3 has levelled off. If the target of 1,000 institutional beds is achieved, perhaps 750 to 800 should be equivalent to Level 3, and 200 to 250 Level 4. As the elderly population grows, with increased longevity, it may be anticipated that more beds will be needed, with perhaps a greater proportion of needs corresponding to Level 4.

D. Recommendations

29. *The home care program should be expanded over three years to become capable of handling an average caseload of 1,300 post-acute care and long-term clients, of whom 900 to 1,000 will be senior citizens; but the expansion should take place based only upon clearly identified needs.*
30. *Day hospitals should be planned as part of the continuum of care once demonstration projects have proved their worth, with provision for 20 to 30 places in the area in the long run.*
31. *The Sherbrooke Community Day Centre should be evaluated, and if it proves successful, an additional center should be provided in the city to expand total capacity to 100. There should also be provision for delivering comparable services to rural centers, or transporting rural clients to urban facilities.*
32. *A long range goal of 750 sheltered housing units should be set, involving modification of existing units, construction of new units, or both; and some of these units should be located in the rural area, based on demand.*
33. *There should be a long range goal of 1,000 institutional beds for senior citizens, based on 5% of the population over 65.*
34. *There should be 200 to 250 Level 4 and 750 to 800 Level 3 beds for senior citizens, based on current demographic data and perceived imbalances in the system; but the Level 4 proportion may be expected to increase as the number of very old residents increases, with a concomitant need for more beds in total.*

VIII. EDUCATION IN GERONTOLOGY

The Division of Geriatric Medicine at the University of Saskatchewan will focus renewed attention on the training of physicians and other health workers for service designed for the elderly. As well, the proposed Geriatric Assessment Unit at University Hospital will concentrate clinical teaching on precise, lengthy diagnosis of unique and multiple disorders. Both of these facilities may overcome some of the gaps which have existed in the health system for decades.

The elderly in Saskatchewan may comprise as much as 20% of the population during the next century, and may be afflicted with perhaps half the health problems existing at any given time. Obviously, all health workers and training courses should in time develop a substantial orientation toward senior citizens.

It is a matter for some debate whether or not geriatrics should become a defined specialty (at the other end of the scale, say, from paediatrics), or whether ultimately physicians and other health workers should as a matter of course be geriatricians with significant elderly caseloads and awareness

of geriatric peculiarities. The Medical Practice Committee of the Canadian Medical Association has indicated that geriatric medicine should largely be the province of family practitioners. If indeed half the health problems will occur among the elderly, one could make the case that all family practitioners will have to be "half geriatricians" if the system is to respond to existing need. If, though, only certain physicians go on to specialize in geriatrics, there is the danger of other colleagues referring their elderly clients routinely when this is unnecessary. In other words, it is possible that some physicians will dispense their elderly caseload to the care of geriatricians to concentrate on more "attractive" patient categories.

As the entire area of geriatrics and geriatric education is new to Saskatchewan, and the continent for that matter, it is difficult to determine the precise direction programs should be moving in. If it is desirable for all physicians to spend a good deal of time with the elderly, fee schedules will have to acknowledge this activity as a priority and if not reward, at least not penalize those who take the time to do a careful work-up and diagnosis. So, too, will the entire medical school curriculum have to incorporate a strong orientation toward geriatric problems. As is already being done, prospective medical students will have to be made aware that an interest in medicine will increasingly mean an interest in the elderly; being able to devote a general or family practice exclusively to the young will be, if it is not already, a luxury of past.

Other health discipline training will have to recognize geriatric problems as paramount as well. For example, in the near future over 50% of hospital utilization will occur among the elderly. It would appear reasonable to emphasize care of the elderly in the academic as well as the clinical portion of nursing training. As long overdue emphasis is placed on the rehabilitation of the elderly, occupational and physical therapists will perhaps play more prominent roles in assessment and prescribing treatment regimens. With more and more drugs on the market, pharmacists will have to be aware of uniquely geriatric contraindications and side effects, and play a more visible role in the health team than they do at present. In addition, new categories of geriatric aides may have to be developed for expanded community based programs.

Many venues for clinical education exist in the form of special care homes. There is much to be learned by spending educational time in Level 3 and 4 institutions, not only to become acquainted with chronic illnesses, but to gain experience in seeing clients for whom health maintenance is the most optimistic prognosis. It would be worthwhile looking into the possibility of rotating interns, residents, and other categories through Level 3 and 4 facilities as a formal aspect of clinical education, bearing in mind that need to maintain licensing status in other areas and to meet accreditation standards for training programs. Perhaps amendments in the clinical curriculum could be affected jointly with other schools.

Recommendations

35. *The Division of Geriatric Medicine at the College of Medicine of the University of Saskatchewan should serve as the focal point*

for education in gerontology among all health professionals, with academic and clinical resources available to an appropriate range of students.

36. *All health professions should as a matter of course become generally more oriented toward the elderly in recognition of the changing nature of the population and the prevalence of health problems among senior citizens.*
37. *All family physicians should devote a considerable proportion of their time to senior citizens as part of the effort to meet the high service needs of this segment of the population, regardless of whether specialized geriatricians are trained in the province.*
38. *The Medical Care Insurance Commission should review payment criteria for geriatric assessment with a view to making the necessary adjustments to encourage physicians to take the time to perform appropriate work-up and diagnosis of problems peculiar to, or more complex among, the elderly.*
39. *Interns, residents, and other health professionals should be rotated through Level 3 and 4 institutions as part of their training course, bearing in mind the need to maintain licensing status in other areas and to meet accreditation standards set by national bodies.*

IX. VOLUNTARISM

Volunteers are crucial to the success of community service and institutional programs. Not only do they fulfill functions which may reduce the need for additional paid staff. They also provide understanding, empathy, and friendship where such qualities are difficult to foster in more regimented staffing circumstances due to heavy workload.

Voluntarism works best when it is recognized that volunteers need certain amounts of orientation, recognition, and direction. In other programs where the volunteer corps has been particularly active, it has proved worthwhile to hire coordinators to ensure that the personnel are trained to meet needs and to introduce innovative areas of participation in the system. These paid personnel have traditionally worked in institutions, where caseloads are large and volunteers are concentrated.

For the elderly, visits from volunteers in their own age group can be especially fruitful, although one should be cautious in guessing what senior citizens prefer. The "young old" from 65 to 74 may constitute an untapped resource of healthy, active citizens with an understanding of the aging process and reservoirs of unused energy suitable for volunteer work.

It may also be a mistake to confine volunteer work to menial tasks and friendly visits. For example, volunteers might, with suitable training, participate in patient education activities, especially where full time staff do not have time to inform clients of all aspects of their circumstances. They might

aid in information gathering and even survey interview processes, given their knowledge of and contact with clients, thereby adding an extra dimension to program evaluation from the clients' point of view. In some cases, volunteers could help with record keeping, filing, or administration — particularly people who want to devote some time to volunteer work but who are uncomfortable with direct contact with clients.

The matter of recognition of volunteers is vital to the success of the program. One thought, and a very tangible one at that, is to equate volunteer work with other forms of charitable donations, making it eligible for tax deductions and/or credits. To make this system equitable, there should be a flat rate deduction from income tax payable for each hour of volunteer work up to a specified maximum; keeping track of hours worked could be one of the duties of the volunteer coordinators. Attaching this benefit to the income tax process makes it possible for the province to implement the policy without federal participation, although Ottawa compliance is highly recommended. The amount of money need not be large, so long as it signifies society's appreciation of those willing to give of their time in a worthy cause.

Recommendations

40. *The development and use of volunteers throughout the service system should be encouraged.*
41. *There should be a District Volunteer Coordinator to promote the greater use of volunteers, especially in community service programs; to coordinate seminars on the expanded training and deployment of volunteers in innovative areas; and to provide assistance to volunteer coordinators in the system as necessary.*
42. *The provincial, and perhaps the federal government should develop a tax credit plan to recognize work as a form of charitable donation.*

Table 3.1 — Possible Locations for Delivery of Major Geriatrics Services.

Service	Place of Residence			
	Farms/Rural Routes	Hamlets/Villages	Towns	Saskatoon
Initial Public Health Nurse Assessment	Home	Home	Home	Home
Additional non-medical multidisciplinary assessment	Home for Social Worker Town * /Saskatoon for PT/OT	Home for Social Worker Town * /Saskatoon for PT/OT	Home for Social Worker Town * /Saskatoon	Home for Social Worker Day Centre PT/OT
M.D. Assessment	Town * or Saskatoon	Town * or Saskatoon	Town * or Saskatoon	Saskatoon
GAU + Assessment	Day Hospital Saskatoon	Day Hospital Saskatoon	Day Hospital Saskatoon	Day Hospital Saskatoon
Outpatient	University Hospital Village * /Town/City	University Hospital Village * /Town/City	University Hospital Town	University Hospital Saskatoon
Inpatient	Home	Home	Home	Home
Activities Recreation	Home or Social Centre Town Centre * or City	Home or Social Centre Town Centre * or City	Home or Social Centre Town Centre * /City	Home or Social Centre Day Centre
Homemaking, Nursing, Handyman Repair	Town * or Day Centre	Town * or Day Centre	Town * or Day Centre	Day Centre
Meal Services	Town or Saskatoon	Town or Saskatoon	Town or Saskatoon	Saskatoon
Basic Therapy (aides)	Town * or Saskatoon	Town * or Saskatoon	Town * or Saskatoon	Saskatoon
Intensive Therapy (PT/OT) †	Town or Saskatoon	Town or Saskatoon	Town or Saskatoon	Saskatoon
Basic Public Housing	Town * or Saskatoon	Town or Saskatoon	Town or Saskatoon	Saskatoon
Sheltered Housing	Town or Saskatoon	Town or Saskatoon	Town or Saskatoon	Saskatoon
Levels 1 & 2 (short-term)	Saskatoon short run	Saskatoon short run	Saskatoon short run	Saskatoon
Levels 3 & 4	Town * long run	Town * long run	Town * long run	Saskatoon
Level 6 (acute)	Saskatoon **	Saskatoon **	Saskatoon **	Saskatoon

* Possible location for delivery given sufficient demand and availability of staff and facilities.

+ Geriatric Assessment Unit

† Physical and occupational therapy

** Except for those using Borden Hospital

CHAPTER 4

PROGRAM ORGANIZATION

The service patterns discussed and recommended in the previous chapter cannot successfully be delivered and evaluated without an appropriate geriatrics program organizational structure. In fact, we regard a well developed organizational framework capable of carrying out a series of crucial functions as a prerequisite for the successful implementation of a comprehensive range of services for the elderly. The issues involved in determining the precise structure are complex, and the nature of the decisions taken will bear heavily on whether or not the shift in emphasis toward expanded community based services can be achieved.

I. GENERAL AUTHORITY STRUCTURE

A. Current Problems

There is presently no authority with recognized jurisdiction over community and institutional services throughout the project area. The City Health Department is responsible mainly for public health services to children and adolescents; immunization services; and public health inspection, as well as formal licensing and regulatory authority over private special care homes. Its services by and large do not extend in large volumes to senior citizens. The Saskatoon Rural Health Department has more or less identical responsibilities and emphases in the surrounding municipalities. The provincial Department of Health either funds or regulates Levels 4 and 6 institutions, and provides grants for home care throughout the District, while the Department of Social Services provides indirect funding of Levels 2 and 3 care and enforces standards for Levels 1 to 3. The latter Department also funds a number of community programs and the Saskatchewan Assistance Plan, an income supplement program.

To date, there has been no coordinating body with formal, established authority to weld community based and institutional programs into a single, fluid continuum as recommended above. Program funding and activities such as client assessment, referral and placement, program evaluation and regulation, standards setting and enforcement, and service innovation and expansion have traditionally been carried out in a fragmented manner. While some useful relationships have developed among agencies and institutions, by and large communications have been informal, unstructured, and dependent on individual contacts and preferences, rather than developed in response to systemic needs.

Into this void have appeared three principal actors with somewhat dissimilar, but clearly overlapping interests. The Saskatoon Provisional Board of Health has sought to amalgamate the city and Rural Health Region under a single authority responsible for a complete range of

health and social services. To date, it has not proved successful in this endeavour. The provincial Department of Social Services has created a policy calling for the creation of a District Home Care Board responsible for the administration of funds and other aspects of program development. As an added complication, this Task Force was established to design a demonstration geriatrics program which of necessity includes services and authority patterns common to both the Board of Health proposals and home care.

The Task Force has advocated boundaries conforming to the home care district envisioned by the Department of Social Services. We also advocate the rationalization of all health and social services under a single governing Board in the area. Unfortunately, the municipalities surrounding Saskatoon were not unanimously in favour of the amalgamation proposal put forth by the Board of Health, so a smaller scale amalgamation may not be significantly easier to achieve than the larger design. Furthermore, as additional home care funds will be forthcoming only upon the establishment of a duly constituted Board, there is the very real possibility of these funds being held up if the District awaits successful amalgamation negotiations. Finally, there remains the question of how quickly and with what authority the provincial Government wishes implementation of the geriatrics project of which home care is an essential, but not the only, component.

It should be evident that the organizational discussion and proposals of this report apply only to the general coordination and rationalization of services. In no way will implementation of our recommendations reduce the need for the continued participation of governing boards in the affairs of individual agencies and institutions. Indeed, the day to day operations of service groups will continue to be responsible to governing boards in the traditional manner; in no way will the District office become involved in purely internal affairs.

B. Capabilities of the Geriatrics Program Board

While the authority complexities in the area are baffling, we are committed to recommending a structure capable of performing the functions required in a successful geriatrics program. Whatever Board is sanctioned to oversee the geriatrics program should be able to carry out the following duties:

1. The administration of home care funds; additional geriatrics program grants; and advising on expenditures in the institutional sector as part of a general shift toward community based services.
2. The recruitment of staff capable of carrying out crucial developmental and management functions, particularly in the start-up phase.
3. The active participation in innovative development of new and expanded services, assessment, placement, monitoring, record keeping, and evaluation activities, etc.

Table 4.1 — Characteristics of Geriatrics Program Board Options

Board Composition	Administration of Home Care & Other Funds	Recruitment of Appropriate Staff	Active Participation in Developments	Legitimacy in Rural Areas	Integration With Rest of System	Speed of Implementation
Current Saskatoon Board of Health (Provisional Board)	Ineligible for home care; some experience in administration of health programs	Additional health expertise would be needed	May require additional expertise and experience for full understanding and control of new program	Acceptability may not be total outside Saskatoon	Theoretically guaranteed, but not without home care funds	Fast in city, slow in rural areas
Reconstituted Board of Health	Could be eligible for home care and capable of overseeing health system	Capability could be built into selection process of Board members	Real control and understanding possible	Should not be a problem if properly structured	Guaranteed given wide range of responsibilities	Somewhat slower, especially if rural areas balk
New Home Care Board	Home care funds automatic; other funding could be channelled here	Capability could be built into selection process of Board members by province	Real control and understanding possible	Should be no problem given provincial criteria	Could be a big problem if poor communications with other Boards	Could be quite swift if negotiations begun early
Interim Home Care & Geriatrics Board	Guaranteed responsibility for appropriate program funds	Capability could be built into selection process of members	Should be guaranteed by appointment process	Should be no problem with proper selection criteria	Could be no problem with provision for transfer to amalgamated Board of Health	Best prospect for quick development

4. The provision of a suitable range of services to rural areas, with legitimate authority acknowledged in the nine municipalities involved.
5. The integration of the geriatrics program with other services to avoid unnecessary duplication of administration, staffing, monitoring and evaluation, etc., and to avoid working at cross purposes with other jurisdictions if it proves impossible to establish a single authority for all programs.
6. The immediate development of the standards and procedures necessary for early geriatrics program implementation.

C. Authority Structure Options

Table 4.1 shows the options for the composition of the governing board for the geriatrics program, and the characteristics of each with respect to the capabilities listed above.

1. The Provisional Board of Health, which is also the Saskatoon Board of Health, is ineligible for the administration of new home care funds, according to provincial guidelines. It is not primarily composed of health experts, although it has existed for four years, during which time it has not been especially successful in achieving its goals. Its credibility outside the city, even within the project area boundaries, is apparently not good. These drawbacks make it an unacceptable option to assume control over the geriatrics program, especially in that it could not run the home care program which will constitute the core element of expanded services to senior citizens.
2. A reconstituted Board of Health would have the potential for overcoming all of the problems encountered by the current Board. It could be structured to conform to provincial home care policy criteria, with rural representatives adding to its credibility outside the city and other new members adding to its health expertise. It would eliminate the need for a separate board to run any part of the health system as envisioned in the Provisional Board of Health Report, thereby guaranteeing an integrated approach to services for both young and old and reducing the possibility of needless duplication of activities. The major drawback of this option is that it would require considerable time to select Board members, and the Board would require some months to become fully acquainted with its mandate. In addition, other responsibilities might slow down the development of the geriatrics program unless it were stipulated that this should be a high priority. Nevertheless, a reconstituted Board of Health, with jurisdiction at least in the home care District and eligible for home care funding, is the best alternative, provided that the delay in putting the new structure in place with appropriate legislative authority is not excessive.
3. A District Home Care Board could be set up independent of the Board of Health but in line with provincial policy, and be given

additional authority to round out the geriatrics demonstration project. There are two problems with this option: first, it results in two somewhat overlapping authority structures in the area, which is *prima facie* undesirable; and second, integration of services could be hampered if the Board of Health looks with disfavour on the new structure, and perceives its own credibility to be undermined by the placing of a major new program thrust under a new authority. The tensions inherent in this option make its chances for success rather poor.

4. If the Government wishes an immediate start on the geriatrics program including home care, it may wish to bypass lengthy appointment processes and local jurisdictional problems by setting up an Interim Geriatric Board which would be dissolved once an amalgamation under a single reconstituted Board of Health has been achieved. This Interim Board could be given the required authority to develop and administer home care and additional geriatrics program functions, and could report to the Provincial Government. If it were clearly understood that its authority would be valid for a limited period of time, contingent upon the amalgamation of the municipalities in the service area, tensions could be reduced considerably. However, the problems with this option are considerable: first, if the Board reported only to the Provincial Government, local interests would perhaps object that the goal of decentralization was not being fulfilled; and second, the Interim Board may proceed in directions contrary to the designs of the City Board of Health, resulting in potential short- and long-term problems. This is, however, potentially a workable option, particularly given good will among all parties involved and with emphasis on immediate development of program components in full consultation with the appropriate groups. Should it prove impossible to set in place a reconstituted Board of Health, the Interim Board appears to be the only workable alternative.

We must emphasize that we recommend a reconstituted Board of Health as the governing authority for the geriatrics program only if it is able to discharge all of the functions required for successful implementation. If it does not appear that a new Board of Health will be able to fulfill these obligations in the foreseeable future, the geriatrics program may not develop properly in the crucial early stages. While we are firm in our conviction that there should be a single governing Board in the District, our primary concern is that the geriatrics program is overseen by a competent and legitimate body. Should the Board of Health not be able to develop the program appropriately, we have no alternative but to advocate the Interim Board option with provision for later transfer to the general health authority.

D. Recommendations

43. *The governing authority for the geriatrics program must be capable of administering home care funds; delivering services to the rural areas as a legitimately perceived authority; actively*

designing and implementing the required innovations and procedures vital to the success of the program; recruiting capable program staff; coordinating geriatric services with the general health system; and beginning program development as soon as possible.

44. *A Board of Health able to discharge the required duties with appropriate legislative authority in the District should be the governing authority for the geriatrics program, as well as other health services.*
45. *There should be no duplication of governing authorities for health services in the district unless the Board of Health is unable to develop the geriatrics program, including home care, in the desirable fashion; in which case the geriatrics program should initially come under the authority of an Interim Geriatrics Board which might report to the Provincial Government, with provision for the transfer of its authority to the Board of Health after a specified time period.*

II. EXTENT OF CENTRALIZATION

A. Discussion and Alternatives

Some aspects of the geriatrics program will have to be centralized in order to achieve efficiency, while for others, decentralization will be more suitable in order to avoid needless bureaucracy and inappropriate centralized control. The decisions to centralize or decentralize various functions should be based on rational and clearly understood principles so that the logic underlying various measures is readily apparent and accredited by the service system's components.

Theoretically, the major advantage of centralization is that it provides the ability to control the parts of a diverse and complex system. The more items are centralized, e.g. budgeting, evaluation, assessment, staffing, and so on, the more easily are standards maintained and anarchic tendencies among organizations curtailed. Centralization in theory enhances potential for rationalization and efficiency.

Centralization has, however, theoretical disadvantages. The distance between the central authority and participating organizations may become considerable. Communications may become infrequent or break down altogether; there may develop resentment of an externally imposed bureaucracy; agencies may consciously or subconsciously attempt to subvert standards and procedures; and morale could deteriorate among workers who feel they have a great deal of service responsibility without any appreciable control over important program decisions. Local peculiarities and special needs can be ignored if flexibility is sacrificed in the name of neatly packaged guidelines and regulations. Central staff can become aloof and arrogant, losing touch with the service network they are supposed to oversee and improve.

Decisions regarding centralization ultimately depend on what is

supposed to be accomplished in various functional areas. These in turn are related to questions of efficiency, uniformity, and accountability. For example, in certain areas organizations will be individually accountable for their performances; in others, the system as a whole must be accountable to provincial funding authorities. The major principles in ascertaining whether program aspects should be centralized or decentralized are as follows:

1. *Efficiency.* Any functions which can be carried out more economically at a central level should be centralized, or decentralized if the reverse is the case, other things being equal.
2. *Accountability.* Wherever the system as a whole must be accountable, activities necessary for the successful evaluation of local services and programs should be centralized to the extent that information is standardized and accessible to a single source.
3. *Uniformity.* Activities which should be carried out uniformly throughout the system, e.g. minimum standards, record keeping, accounting, etc., should be centrally directed and overseen, but may be carried out on a decentralized basis within the framework of general policy.
4. *Functional Capacity.* Bearing in mind the above principles, any functions which can be successfully carried out on a decentralized basis should be so performed, either with or without central direction, with a view to keeping central staff and activities to a viable minimum.

B. Recommendations

46. *Activities necessary to promote economic efficiencies, systemic accountability, desired procedural uniformity, and similar benefits should be centralized.*
47. *Any activities which can be carried out on a decentralized basis, bearing in mind the principles listed in Recommendation 46, should be decentralized, with a view to providing all services, and as much of the administration as possible, without the need for additional central bureaucracy.*

III. ORGANIZATIONAL FUNCTIONS

A. Budgeting, Service Procurement and Delivery

It is common for local agencies to obtain funds in Regina and occasionally elsewhere on a fragmented basis, with no prior consultation with local colleagues and no set notions of how their activities affect the system as a whole. In other words, there is no local forum for rationalizing budget requests and allocating expenditures throughout the system according to established client needs. While all of the reasons for this phenomenon are not immediately obvious, the in-

ventory survey did reveal agency perceptions not conducive to optimal cooperation and consultation (see Appendix 2D, pp. 187-210).

In our view, it is impossible to effect the desired coordination of services without vesting significant funding authority in the Board governing the geriatrics program. If programs are to be assessed, and funds allocated on the basis of overall systemic needs and characteristics, there must be a District authority responsible for budgeting. In effect, this would in some cases mean a decentralization of the budget process to the District level from Regina, with a view to coordinating agency activities with the findings of client assessment processes.

Local budgeting would result in more direct accountability of programs because those responsible for allocating funds would be on the scene to monitor expenditures and program performance. Flexibility could be built into the system because changes in client needs and agency capacities and performance could be detected quickly and responded to without having to seek approval from Regina.

While the District office should be responsible for budgeting, it is intended that funds actually be dispersed throughout the system. There appear to be sufficient organizations in the area capable of developing and delivering the required service programs on a contract basis. Organizations should submit proposals to the District Administrator, and the two parties should negotiate the terms of agreements to ensure that all program standards are met and all possible efficiencies achieved. Because there appears to be considerable capability already in the system, services should be funded and delivered on a contract basis wherever possible.

The scope of funding authority is a matter of some difficulty. Without doubt, the Board should control and administer home care funds, plus additional grants for specifically geriatrics program purposes. The budgeting for all community organizations whose clientele is primarily elderly should fall within the same administrative framework. Particularly if the general Board of Health authority is put in place, all community services should be funded in the same contractual manner, with global grants flowing initially to the District office.

Institutions present a special problem in view of their nature and the huge amounts of money involved. In the initial phase, it is not reasonable to expect the District office to be able to evaluate properly the expenditures in special care homes and hospitals, with a view to shifting resources if required. Institutions exhibit a phenomenal inertia regarding funding requirements — particularly special care homes, which are residences, as well as care facilities, and hospitals, where demand will inevitably expand to meet supply. A rationalization of expenditures involving shifts from the institutional to the community sector will in any case not occur until the latter services have been expanded and have proved their worth.

Given this situation, it is preferable initially to limit direct budget authority at the District level to the community services sector and ancillary functions such as assessment and program evaluation. This provides the opportunity to concentrate efforts on improving the community sector; it also avoids giving an illusion of authority over huge amounts of institutional money where no immediate foreseeable possibility for change exists.

This limitation does not preclude the District office from acting in an advisory capacity concerning Government assessment of institutional budget needs, particularly once the assessment system has been implemented and evaluative criteria have been developed. This role ought certainly to extend to the housing sector.

In the long run, it may be desirable to have all budgeting for community and institutional services handled at the District level. A properly functioning community services sector should ultimately eliminate the need for Levels 1 and 2 care; the District directorate should be empowered to reduce expenditures in these areas as part of the long-term goal of funding institutional care only where it is absolutely necessary. If community care and institutional care are to be considered as components of a single continuum of service, it is indefensible to monitor budgets and expenditures locally for the former and centrally in Regina for the latter. Perpetuating differences in the two types of service will only serve to reinforce the notion that community based programs are less important and in need of more intensive examination than their institutional counterparts. Whether or not this process includes acute care hospitals is not at present crucial to the concept, although there should be formal coordination of community services attached to acute care facilities with ties to the assessment, placement and general budgeting system.

Recommendations

48. *Budgeting for home care and other community based geriatrics services should be handled through the District Office Administrator; global grants from funding sources should be turned over to the governing Board, for dispersal to service organizations.*
49. *Services should be procured and delivered on a contract basis, negotiated initially by service agencies and the Administrator and approved by their respective Boards.*
50. *The District Office should not directly administer any service programs unless specifically requested to do so by service providers, and if it is economically efficient to do so.*
51. *Initially, direct budgeting authority should apply to the community sector, with an advisory role to Government regarding the institutional and housing sectors; but in the long run, the Board of Health should perhaps have funding authority throughout the*

service continuum to ensure maximum coordination and efficiency.

B. Assessment, Referral, Placement and Case Coordination

1. Current Problems

The inventory survey revealed that service providers regard the implementation of an assessment, referral and placement service as the number one priority for development. Age Concern, a broadly based Saskatoon group interested in improving services to the elderly, has been discussing the issue for a number of years, and has prepared a proposal for an assessment and placement mechanism.²⁵ It would appear, then, that the service system is prepared to participate in a properly conceived and implemented process.

At present, assessments in the community sector are carried out with various, non-standardized criteria for determining kinds and volumes of service needed and no common method of ensuring that those in greatest need are served first. The University Home Care Program appears to have the most intensive assessment process, although it has not been thoroughly evaluated. Other agencies assess with varying degrees of precision; the survey results report that few use standard assessment forms, and many organizations do not have formal criteria for determining client eligibility for admission to programs. There are no system-wide waiting lists or screening programs for the elderly at risk in the community.

In the institutional sector, Level 4 assessments are carried out by a regional committee; no doubt the fact that Level 4 care is fully insured has provided some impetus to rationalize and monitor admissions. Level 3 care, where every client is subsidized at the rate of \$430 per month by the Department of Social Services, requires a physician assessment, as does Level 2, subsidized at \$144 per month per client. Level 1 is unsubsidized, and assessments are not formally monitored in any way.

The Level 2 and 3 assessments are not standardized, and there is no formal coordination of waiting lists and no evaluation of the accuracy of the procedure. For Levels 1 and 2, there are no formal provisions for ensuring that prospective clients are assessed for suitability for community based services at home. By and large, funding and administrative arrangements encourage special care homes to make sure that all beds are filled. Whether or not they are filled with the most appropriate clientele is another matter, and this has not hitherto received structured, community-wide attention.

Acute care hospitals report that long-term stays could in some instances be curtailed if there were a placement mechanism designed to facilitate the flow between Level 6 and Levels 3 and 4. Clients have remained in hospital for over a year awaiting appropriate placement in other facilities, at enormous public expense.

2. Experience in Other Jurisdictions

The Hamilton District Health Council has operated an Assessment and Placement Service (APS) for 6 years, during which time it has developed valuable credibility among physicians and nursing home operators. It is a voluntary system in that neither clients nor program managers are required to use the assessment procedures or follow the recommendations for placement. Physicians, nurses, and social workers working in the system complete a detailed, two part form, which is then sent to the APS office for review by three full time Counsellors (at present all nurses), who make recommendations based on the data recorded and arrange suitable placement if possible.

Given that the service is not mandatory, the Hamilton APS has achieved some commendable results. However, the service is at times circumvented precisely where it is most needed if services are to be rationally apportioned. For example, nursing home operators maintain their own waiting lists, and may select "light care" clients ahead of "heavy care" clients for largely economic reasons. In addition, some institutions and community services remain outside the system, which makes thorough evaluation of all programs difficult.

The Ottawa-Carleton District Health Council operates a Patient Placement Coordination Service (PPCS) whose primary goal is to expedite the appropriate use of institutional beds. The system has been in operation for less than three years; while its structure is basically similar to Hamilton's, it does not appear to have ironed out problems quite as well, which is understandable. The PPCS system is gradually becoming perceived as useful and legitimate, but difficulties also common to the Hamilton APS are clearly present.

The average cost per referral in both Hamilton and Ottawa was roughly \$50 in 1976; each placement effected in Hamilton cost about \$85. These costs may be add-ons to the system because the central offices do not actually carry out the assessments. The main potential savings are in the administrative process, and these are reduced by the fact that most participants use the service for only part of their caseloads. Hamilton has 8 administrative, counselling, and support service positions in its central office; Ottawa has 6. The annual referral load is roughly 2,500 in both instances.

The province of Manitoba has implemented an integrated system of community and institutional care to the extent that all prospective clients of all programs undergo a mandatory assessment and placement process, provided that public funds are involved. It has not yet been possible to develop a single form for use in all assessments, though this is seen as a long-term goal. No clients are admitted to partially or fully government-insured programs without an assessment and recommendation; the decisions of Regional Assessment Panels can be appealed and overruled in theory, but such cases are rare.

Nursing homes may designate up to 10% of their beds as preferred

accommodation for admission of clients who have not undergone the standard assessment, and who pay the full cost of care. This option is infrequently used because only rather wealthy clients can guarantee total payment for possibly decades. Similarly, clients may solicit and pay the entire cost of community based services without undergoing assessment. In other words, the system can be circumvented only by clients willing to pay the entire unsubsidized cost of accommodation and care to organizations willing to provide service on that basis.

The Manitoba system has been operating for four years, and whatever initial resentment existed among service organizations has largely been dissipated. Clients retain complete choice over whether or not they wish to use services; administrators may refuse to serve certain clients provided there are legitimate reasons for doing so. The key to the success of the process is frank and continuous communication.

The role of assessment and case coordination is frequently combined, particularly in the rural areas. For example, a public health nurse might perform the initial assessment; recommend service delivery; have the recommendation approved by a Regional Assessment Panel; assume responsibility for obtaining services from local agencies and personnel; do a reassessment; and cancel the services if appropriate. In this way the assessor is able to see the results of recommendations, and is able to refine the process to a high degree of competence.

3. Preferred Options for the Geriatrics Program

Based on the perceived need in Saskatchewan, the experience of other programs, and the logic and consequences associated with various options, the Task Force has concluded that an assessment and placement service should be operated at the District level with the following characteristics:

- a. The service should be mandatory for all prospective clients of publicly funded community and institutional programs, from home care through Level 4, including Level 1, which although not directly subsidized, is the recipient of property tax concessions and has clients who are frequently recipients of Saskatchewan Assistance Plan subsidies. While there are arguments in favour of a voluntary system, it seems apparent that this option allows for crucial avoidance of the procedure with severe consequences for bed utilization and placement of clients in order of priority of need. Furthermore, it would seem to be impossible to evaluate a voluntary service in relation to the needs of the system because a significant number of clients would fall outside its jurisdiction. A District service must inevitably involve additional personnel and funding; this expense can only, in our view, be justified if it has an excellent chance of rationalizing assessment and placement in the interests of all clients and all service providers on an equitable basis.

- b. There should be a Director of Assessment and Placement responsible for initiating the procedures leading to full implementation of the process. These would include assembling a working group from the community to develop forms and criteria for placing needs in order of priority; pre-testing these mechanisms; compiling an inventory of service organization characteristics so that particular nuances and other legitimate concerns are taken fully into account in the process of matching clients and programs; recruiting and training assessment personnel; and publicizing the service throughout the service area. This person will also oversee the system once it is operational, and attempt to solve continuing problems.
- c. The service should be capable of performing 2,000 assessments annually, including reassessments. It is reasonable to expect that each assessment will require an average of 7 to 8 hours, including single or multidisciplinary assessment; District office determination of needs in order of priority; and referral to and placement in the appropriate programs. Approximately 8 full time personnel would be required.
- d. Assessment personnel should include:
 - 4 Public Health Nurses**, who will be the core of the system and who will determine the need for multidisciplinary assessments;
 - 2 Social Workers**, who will provide environmental and social assessments as necessary;
 - 1 Physical Therapist**, who will determine the rehabilitative potential of a significant number of clients;
 - 1 Occupational Therapist**, who will assess client potential for continued or reacquired independence, and who will be particularly valuable in ensuring that excessive volumes of service are not delivered, creating unnecessary dependencies;
 - 6 Medical Consultants**, retained on a contract basis to carry out 600 to 700 medical assessments per year as required, and to participate in general discussions to refine the general assessment and placement process and evaluative criteria; and
 - The Geriatric Assessment Unit**, to which the task of assessing prospective Level 4 clients should be delegated as long as this classification exists under current funding regulations, and similar clients if the classification system and funding mechanisms are revised over time.
- e. Personnel should be transferred from existing organizations who perform this function at present, in order to guarantee certain economies resulting from centralizing a process previously conducted on a fragmented basis. The University Home Care Program has 3 full time assessors who should be amalgamated into the District system; the Department of Social Services has 3 positions devoted to assessment; and from 2 to 3 positions located in Level

1 to 4 institutions should be transferable to the District office. It may not prove possible for community agencies to provide full time personnel for the District Assessment Unit because the process is not fully developed at present.

It is essential that assessment personnel maintain ongoing and productive liaison with service organizations to which clients will be referred. Experience elsewhere has shown that friction may develop between the assessment office and service agencies if communication breaks down, or policies are not fully understood and accredited by both parties. One method of avoiding such problems is to have assessment personnel seconded from service organizations on a rotating basis. After a year, for example, assessors might return to agencies or institutions to work in the direct service sector, thereby maintaining familiarity with both the assessment/placement and service aspects. However, there are serious problems inherent in this arrangement, such as maintaining continuity at the District assessment level and ensuring that expertise is developed. Furthermore, smaller community agencies may not be able to rotate full time personnel through the assessment unit.

To guarantee that the assessment process will be accountable to the service system, and to avoid the potential difficulties associated with secondment of personnel to the District unit, it is suggested that an Advisory Board composed of service sector representatives be established to monitor the activities of the assessors and indicate the appropriate policies to overcome difficulties. This Board would ensure that the assessment personnel maintain ongoing communications with and knowledge of service programs, and would provide a forum for airing complaints and suggesting revisions in procedure. The Board should also ensure the cooperation of the service sector with the District assessment concept.

- f. The functions of assessment and case coordination should be combined so that service personnel have available one person located centrally with whom to consult regarding problems, need for reassessment, and the like. Furthermore, having assessment personnel take on this role guarantees that they monitor the consequences of their recommendations, and provides an objective means of determining when services should be cancelled — an extremely crucial function which we believe is best performed by one who is not directly involved in service provision.
- g. Clients should retain complete freedom of choice concerning whether or not they wish to make use of a recommended service or bed vacancy, and complete freedom to use and pay the entire cost of services without assessment as long as someone is willing to provide them. At the present time no more than 10% of institutional beds should be set aside for preferred accommodation.

- h. The Task Force heard concerns from some nursing home operators that a central system might upset the development and continued success of worthwhile programs. We recommend that whatever procedures are developed take fully into account legitimate special service characteristics and mix of clientele so as not to place clients inappropriately.

4. Recommendations

52. *There should be a mandatory District Assessment, Placement, and Case Coordination service extending to all prospective clients of community service programs, public housing, and Levels 1 to 4 institutions, where public funds are involved directly or indirectly.*
53. *There should be a Director of Assessment and Placement responsible for designing, testing, and implementing the system, recruiting appropriate staff, and monitoring the system once operational.*
54. *There should be a District Assessment and Placement Unit capable of handling 2,000 cases annually, including 4 public health nurses, 2 social workers, 1 physical therapist, 1 occupational therapist, 6 medical consultants, and other consultants as necessary.*
55. *The 3 assessors from the University Hospital Home Care program, 2 Levels 1 to 4 assessment personnel, and 3 Department of Social Services assessment personnel should be shifted to the proposed District Unit.*
56. *There should be an Assessment Advisory Board, composed of representatives of service organizations and perhaps consumers, to monitor Unit operations, ensure adequate communication throughout the system, and propose changes in policy.*
57. *The Geriatrics Assessment Unit should assess all prospective Level 4 clients, and their equivalents assuming the classification system is revised in the long run; and it should report its findings in order of priority to the District Unit.*
58. *Assessment personnel should also perform the case coordination role, involving the provision of advice and supervision to service personnel; reassessment of clients as necessary; and addition or cancellation of services as needed.*
59. *Clients should retain complete freedom to use or refuse recommended services, or to avoid the standard procedure if willing to pay the entire unsubsidized cost of independently procured services.*
60. *At the present time, no more than 10% of special care home*

Figure 4.1 — Assessment, Referral and Placement Model.

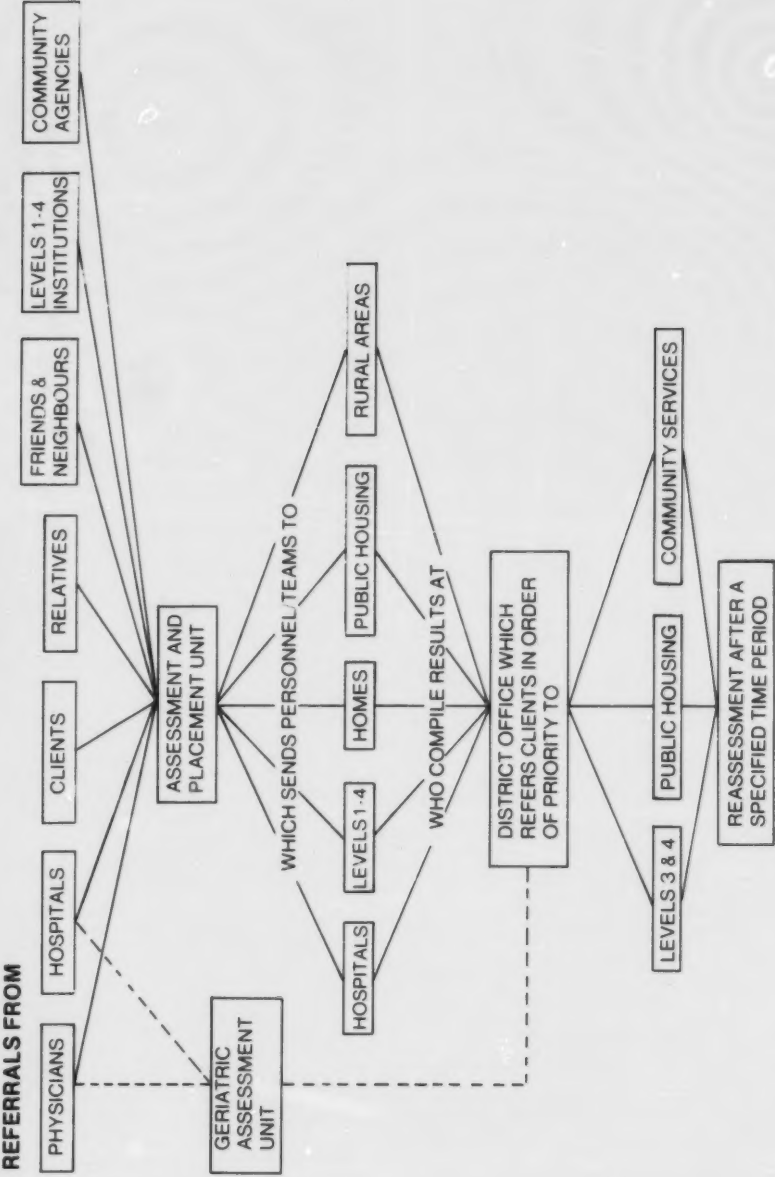
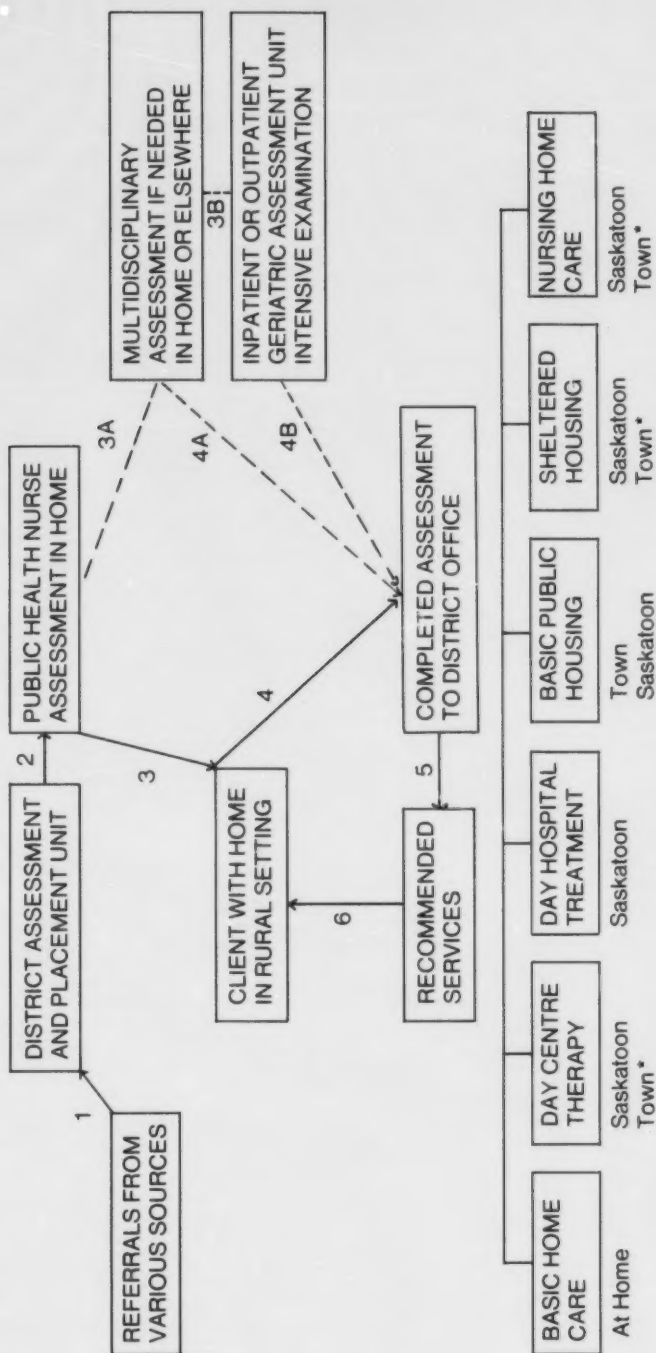


Figure 4.2 — Assessment and Service Delivery Patterns in Rural Areas.



..... optional procedure
 * given sufficient demand and reasonable economic efficiency

beds should be designated as preferred accommodation accessible to clients without assessment.

61. *There should be a formal appeal mechanism against decisions and recommendations made by the Assessment Unit.*

C. Program Standards

If the geriatrics program is to be equitably accessible to all clients with guarantee of adequate quality of service, there must be a uniform set of standards to apply to all participating service groups. The development of appropriate standards is not an easy task, for a balance must be struck in order to avoid setting standards too high for service agencies to be able to meet them in the short term; too low to ensure safe and adequate service delivery; and too rigid to allow for superior quality innovations and performance.

There should be a Director of Standards responsible for developing an appropriate set of standards, in consultation with working groups representing service providers and perhaps recipients. We are aware that the provincial Home Care Directorate will be developing standards covering that aspect of the geriatrics program, and note that there could be some duplication of function. It is therefore suggested that an arrangement be negotiated whereby a provincial standards officer becomes attached to the Saskatoon District geriatrics program pilot project in recognition of the area as a venue for initial comprehensive service development for the elderly. The standards developed would presumably become the model for home care throughout the province, and perhaps for ancillary services for senior citizens as other geriatrics programs are initiated. As the setting of standards is a crucial function which need be performed comprehensively on a one time only basis, it seems reasonable for this position to be funded by the Home Care Directorate of the Department of Social Services rather than the local geriatrics program office, particularly as its results will benefit the entire province.

Among the components of program standards will be at least the following:

1. There must be administrative standards, primarily involving the ratio of expenditures on program direction, recruitment, office/clerical services, office rental, other overhead, etc., to expenditures on direct service delivery. These standards should be flexible enough to account for inefficiencies in the start-up phase and the unique characteristics of certain programs, but firm enough to suggest limits on administrative costs regardless of perceived peculiarities. These standards will come into play when the District office lets contracts for provision of services. Those organizations which cannot deliver so much service for so many dollars per unit will be overlooked in favour of those who can (and who can meet other standards as enunciated below).

2. There must be minimum standards of service quality to guarantee safety and competence; but these should not be misconstrued as maximum standards, and organizations which exceed these standards should be encouraged to continue their high level of performance, provided that costs are reasonable. In some instances, it should be considered reasonable to pay higher per unit costs if indeed the service is of better quality and benefits clients to a greater degree.
3. Personnel and duties should be carefully matched so that tasks performed are appropriate to the level of training and/or demonstrated competence of staff. Emphasis should be on ability to do the job in question, and not solely on educational qualifications, although the two variables will be related. Underqualified staff may not be able to provide a high quality, safe service, while using overqualified staff relative to duties is wasteful and can lead to job dissatisfaction and high turnover rates.
4. Special consideration must be given to the needs of the rural areas. For example, there may be difficulties in attracting specialized personnel to smaller centers, and it may be impossible to justify large capital expenditures for facilities comparable to those in Saskatoon without the prospect of adequate utilization. Nevertheless, it may be possible to offer less sophisticated programs in rural areas, in accordance with the preference of local residents and clientele. If local senior citizens prefer to live in special care homes which are too small to warrant expensive adjunct services and facilities, program standards should not preclude this possibility. Similarly, if highly trained professionals are not available to provide certain kinds of therapy services, it should be possible for more limited versions to be delivered by paraprofessionals trained by, and under the supervision of personnel from Saskatoon. The operative principle should be that the rural areas should be permitted to opt for safe, but limited service delivery on a local basis if travelling to Saskatoon is seen as undesirable. As long as safety is not compromised, some degree of local discretion should be permitted.

Recommendations

62. *There should be a Director of Standards to develop a comprehensive set of regulations governing the delivery of geriatric services during the start-up phase.*
63. *This position should be seconded by the provincial Home Care Directorate in recognition of the importance of the development stage for the entire province; the desirability of avoiding duplication of function; and the one time only nature of the need to undertake this activity on a comprehensive basis.*
64. *Standards should be set governing permissible administrative proportions of total service costs; minimum quality of services,*

with provision for exceeding them at additional cost if desirable; and quantity of service deliverable to clients, based on priority of needs and alternatives available.

65. *Special consideration should be given to the rural areas so that within reasonable limits, standards may be flexible enough to take into account a desire for locally delivered services on a reduced or limited basis in preference to travelling to Saskatoon for more sophisticated and extensive programs.*

D. Information System, Program Monitoring and Evaluation

All programs should periodically demonstrate their utility and efficiency where public funds are involved. This includes general accountability of expenditures and performance in relation to well-defined and understood standards, as well as comparative assessments among organizations.

At present, judging from the survey results, record keeping is spotty and non-standardized, and formal evaluation in the context of the needs of the system as a whole is rare. It is impossible to measure the contributions of various programs, including institutional services, to public well-being, per dollar spent. Even if only as a defensive strategy, the system should seek to implement mechanisms to show its worth, in order to compete for a finite number of government dollars.

Self-evaluation of programs can be useful, but it is rarely objective, and will never deny an organization's claim to continued existence. Self-monitoring can reveal strengths and weaknesses, and can help staff to improve performance. The ongoing availability of information cannot but lead to greater awareness of shortcomings and levels of performance to which organizations should strive to achieve.

If the system is to be evaluated, there must be common standards of performance and uniform data collection in vital areas. To achieve this degree of uniformity where none currently exists requires, it would appear, central direction, along with extensive community participation. Any assessment of the system requires an impartial observer; this would be the District office staff retained to help develop standards, forms, record keeping and submission format, computer programs, etc. In this way, all organizations would be subject to the same scrutiny, using criteria they helped develop.

It is essential to realize that consistent, universal evaluation need not be a lever for attacking individual groups and reducing or eliminating operational funds. It is ideally an ongoing, consultative process, where information is made available to agencies so that they can examine the results for themselves and identify problems without the need for District office intervention. District staff should be available to respond to specific information needs, and to make suggestions for overcoming difficulties. Agencies may wish to see how their counterparts are performing in trying to establish personal goals. Gaps in programming

can be collectively identified, with cooperative means of deciding which organization should be asked (and funded) to meet outstanding needs. Above all, the evaluative process will enable a hitherto fragmented system to demonstrate, with hard data, the value the public is receiving for its dollars. This is particularly important in the community sector, which has traditionally received less emphasis in allocating funds, mainly because its results are less visible because of its preventive, at-home orientation.

In order to produce frequently updated information without involving too much manpower, certain data should be computerized, with easily readable printouts and analyses. Central keypunching and programming using one computer source would result in great efficiencies. Organizations would receive monthly or quarterly printouts related to performance in agreed upon areas, and District office staff would at the same time peruse all the information and make note of special problems and achievements. The data need not suggest difficulties in agency performance; they may rather reveal a need for new services; intensification of effort for certain target groups; or shifting of resources from one area to another.

This report cannot set down the precise nature of the information system. We do urge, however, that those ultimately responsible for developing the system establish clearly what is wanted out of the exercise before determining the detailed records to be compiled. It is of no use to collect information if no one could possibly make use of it. Furthermore, there should be a broad understanding of potential uses, for instance, not only program monitoring and evaluation in the short run, but important, nationally significant research over time. Hence the working group or groups developing the system should include representatives of service providers, administrators, academics, and government, among others. No doubt properly qualified consumer representatives could contribute significantly in this regard.

For certain people and groups, the prospect of computerized information conjures up visions of totalitarianism and other such infringements of rights. While abuse is possible, it can be protected against by means of basic, proven regulations. For example, the Medical Care Insurance Commission retains records of medical histories on all Saskatchewan residents and during its decade and a half existence, breaches of confidentiality have been extremely rare and safeguards have been successfully built into the system. Many private organizations have information on individuals, often without their knowledge, and while this may be annoying and cause for philosophical concern, rarely have cases of clear abuse been reported. It is essential to remember that computers themselves are harmless, passive recipients of coded data. There are numerous precedents suggesting that protection against breaches of confidentiality can be established without serious problems.

This being said, it is perhaps worthwhile to enunciate a number of

principles which should be part of a computerized information and analysis system:

1. There should be regulations governing the release of information on individual clients so that only appropriate personnel have access to these records and do not release information on any basis to outside sources.
2. Regulations should be established governing the release of collective data to other governmental agencies, research individuals or groups, and other potentially interested people, the purpose being to protect individual confidentiality as a matter of course and to ensure that persons given access to potentially sensitive material will use it responsibly.
3. Organizations participating in the system should specify their ongoing data requirements, the type of guarantees they wish regarding access to information on their clients, and so on; and in general, other similar regulations should be negotiated and formally contracted if necessary.
4. Organizations desiring to code and receive information beyond the agreed upon core data to apply to the system as a whole should be able to negotiate these additions and make use of District office evaluation personnel if appropriate.

Establishing the information system and evaluative criteria will be a vital and time-consuming task. This activity will be carried on simultaneously with the development of the Home Care evaluation package. As has been suggested for standards, program evaluation personnel from the provincial Home Care Directorate might profitably be seconded to the Saskatoon area to develop a model suitable for use elsewhere. The process for the geriatrics program, with additional aspects other than home care, will require at least two professional people during the developmental stage, at least one of whom should be funded by Regina in recognition of the provincial significance of the project. As the system becomes operational and eventually routine, a full time position may not in the long run be necessary for the geriatrics project, although such personnel will be required by the Board of Health for general purposes.

Recommendations

66. *An information gathering and program monitoring and evaluation package should be developed for the geriatrics program in consultation with service organizations, academics, and other potential users of the system, with one position seconded from the provincial Home Care Directorate during the developmental stage.*
67. *The data system should be sufficient to record assessment and placement information, service delivery information, outcomes*

resulting from service provision, and appropriate demographic information, with the capability to yield individual organization and comparative evaluation, possible target groups for routine screening and assessment, and indications of service gaps and deficiencies.

- 68. The system should be computerized, with appropriate safeguards regarding confidentiality and provision for meeting additional needs of individual agencies.*
- 69. The District information and evaluation system should not preclude individual organizations from retaining their own records and evaluating their own programs in accordance with particular needs and desires, with help from District staff if requested.*

IV. SUMMARY ORGANIZATIONAL STRUCTURE AND FUNCTIONS

Figures 4.3 to 4.5 and Table 4.2 show the organizational relationship implied by the recommendations, depending on whether or not a single Board of Health will operate the geriatrics program from the outset, or an Interim Geriatrics Board is necessary. It is assumed that Figure 4.4 will be the ultimate configuration regardless of short-term contingencies. It is emphasized that much of the cost of the proposals should be borne either by the provincial Department of Social Services (for Standards and Evaluation positions), or shifts in the system (for Assessment and Placement). Precise financial implications will be outlined in the following Chapter.

Figure 4.3 — Geriatrics Program Funding Organization.

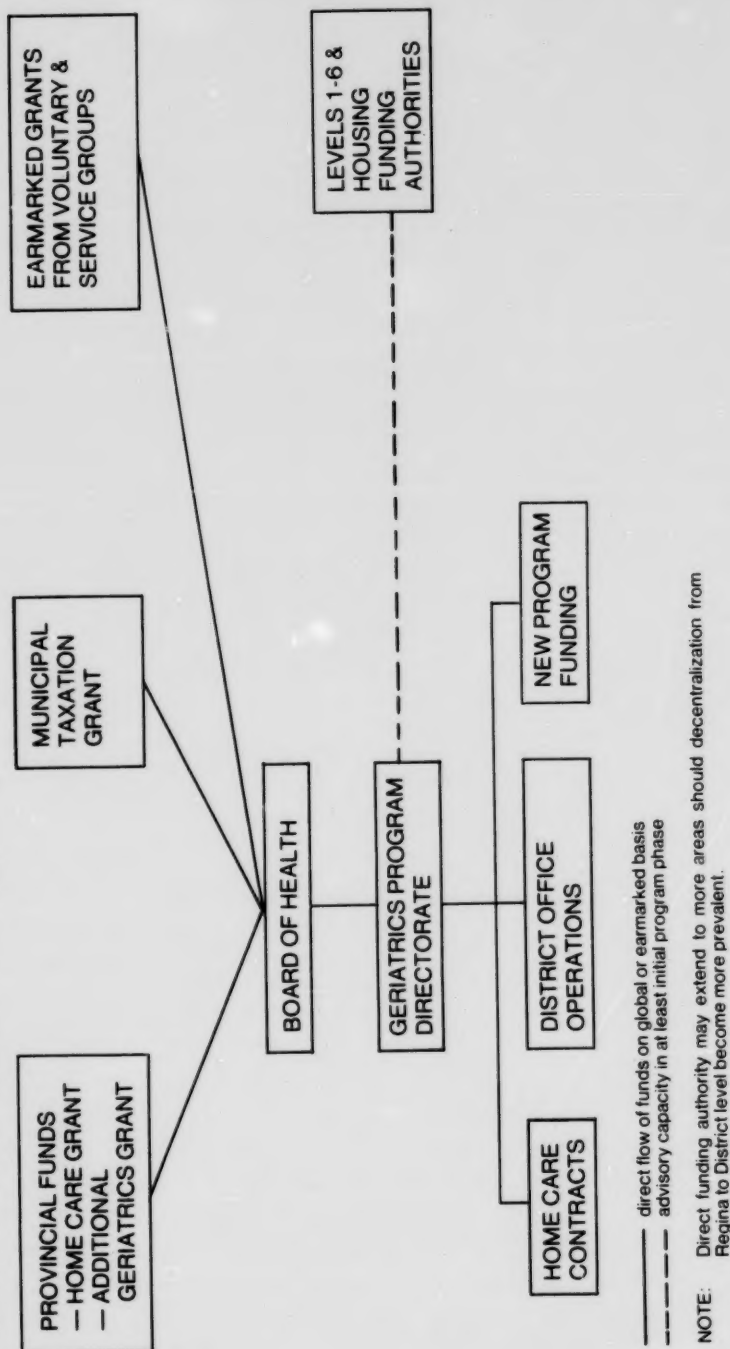
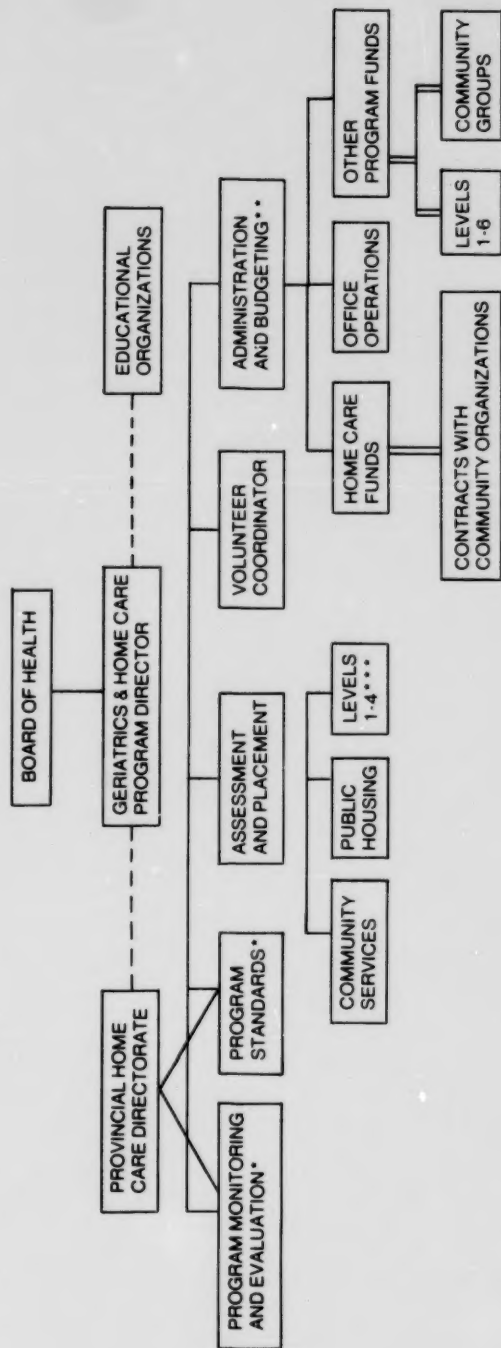


Figure 4.4 — Organizational Patterns for Geriatrics Program Functions.



- * Functions shared with other Board of Health programs in long run to promote efficiencies; in short term seconded personnel from provincial Home Care Directorate should report bilaterally as indicated.
- ** Involves programs primarily, but not exclusively used by senior citizens.
- *** Levels 1 and 2 will eventually disappear from the institutional setting.

— line authority
 --- formal liaison
 === funding authority only — no direct program involvement

Figure 4.5 — Contingency Free Standing Geriatrics Program Organization.

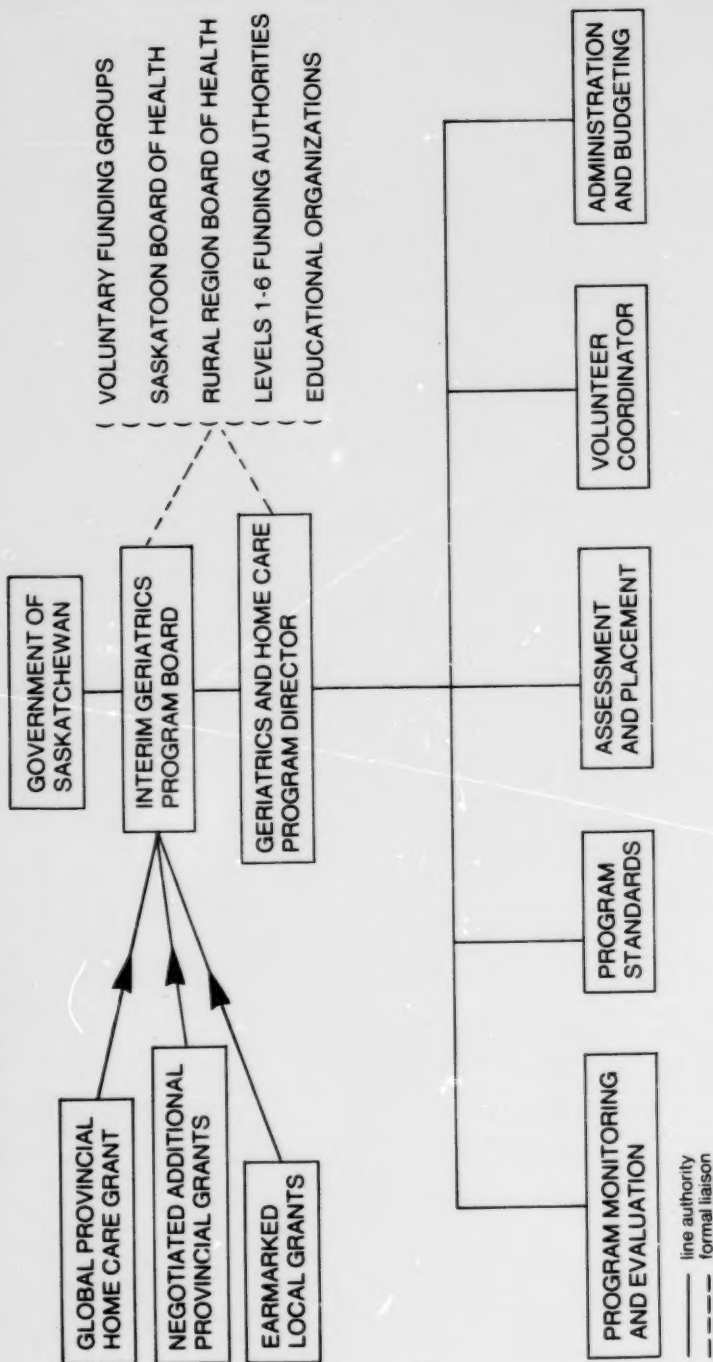
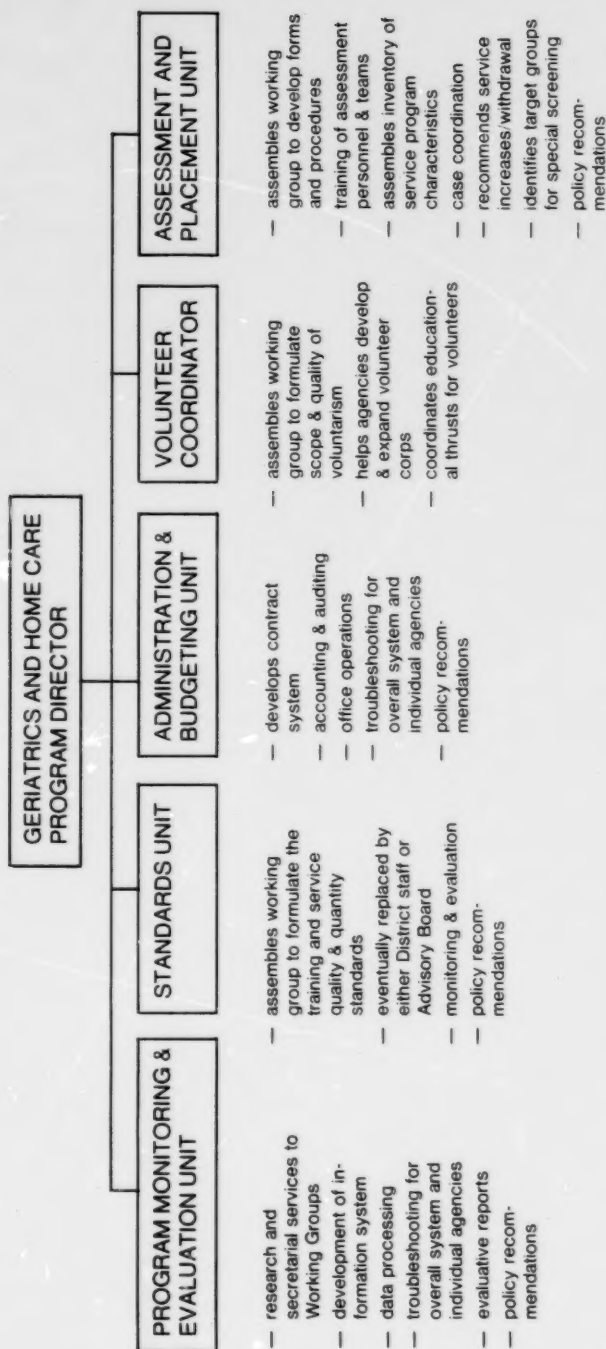


Table 4.2 — Summary of Geriatrics Program Functions.



V. IMPLEMENTATION SCHEDULE

As geriatrics is a high priority concern of the Government (this Task Force being evidence of its importance), every effort should be made to promote early implementation of the recommended program design and features. However, the program may have to await authority structure ratification for the general health system in the area before rational and integrated services can be developed for senior citizens. With commitment to the geriatrics program on the part of all crucial parties, implementation should proceed according to the following schedule:

1. Mid-1978 to January 1, 1979: negotiations among the city, the rural area adjacent, and the province for an amalgamated health authority, including revised legislation and funding.
2. January 1, 1979 to March 31, 1979: new Board of Health put in place, advertisement and hiring for geriatrics program director position also responsible for home care.
3. April 1, 1979 to May 31, 1979: recruitment of staff to fulfill geriatrics program functions, some of which will overlap with other program areas.
4. June 1, 1979 to September 30, 1979: convening of working groups to develop program standards, assessment forms, information system, client referral and placement processes, administrative and contract format, evaluation criteria, etc.
5. October 1, 1979 to March 31, 1980: testing and refinement of products of working group deliberations, and final approval of procedures for commencement of operational program.
6. April 1, 1980: program formally begins, with flow of funds coinciding with beginning of Government fiscal year.

Recommendations

70. *Regardless of which authority will govern the geriatrics program in the short run, the Board should be in place by March 31, 1979.*
71. *Recruitment of District staff and development of forms, standards, procedures, and relationships with service organizations should take place between October 1, 1979 and March 31, 1980.*
72. *The geriatrics program should be fully operational as recommended by the fiscal year beginning April 1, 1980.*

CHAPTER 5

FUNDING PROBLEMS, RECOMMENDATIONS AND IMPLICATIONS

I. PROBLEMS

There are two main funding problems which must be overcome in order to make implementation of the recommendations of the previous Chapters feasible.

A. Distribution of Current Resources

The system is heavily weighted towards institutional care. Saskatchewan has assembled an extensive network of institutional facilities that some would consider excessive. We have recommended a reduction in the proportion of senior citizens who should reside in long-term facilities, and the elimination of lower levels of institutional care. Yet these measures cannot be accomplished easily, for institutions have certain fixed funding requirements regardless of whether or not all beds are filled. In addition, buildings do not disappear when occupancy declines.

There must inevitably be a transitional period during which community service programs expand without appreciable savings in the institutional sector. Furthermore, beds which may not be needed in the short run will certainly be occupied in the long run, given projected demographic trends. For proper use of facilities, a long range master plan should be drawn up to outline potential alternative uses for Level 1 and 2 facilities, and match these with anticipated service demands. It is essential that funding be made available for appropriate decline in occupancy and conversion projects.

B. Client Charges

The assessment of client charges appears currently to conform to no clear and rational set of principles. Time and time again, the Task Force heard of instances where funding regulations work against placing clients appropriately. The situation is most serious in Levels 1 to 4 facilities, the funding of which exhibits the following characteristics:

Level	Direct Government Subsidy/Month	Average Client Charge Per Month	Total Average Cost Per Month
1	NIL*	\$400	\$ 400
2	\$ 144	426	570
3	430	485	915
4	1,500	NIL	1,500

* A small number of clients receive a \$30 per month subsidy, none of whom are recent admissions.

Rates vary from nursing home to nursing home; the cumulative figures presented here are averages. The client charges are not fully paid by clients themselves. Roughly 50% of Levels 1 to 3 residents receive Saskatchewan Assistance Plan benefits which cover varying proportions of the monthly client charge.

Obviously, the most serious funding anomaly pertains to Levels 3 and 4. Level 3 clients may pay up to \$500 and more per month directly, while Level 4 clients pay no portion of the cost of care and accommodation. There is consequently pressure by some families to have their elderly relatives classified as Level 4 to avoid rather prohibitive personal costs. While the District waiting lists for Level 3 admission are short, there is an 18 month to two year wait for admission to Level 4 for most clients who have been assessed at that classification by the proper committee.

It was pointed out to the Task Force that the funding mechanisms for Levels 1 and 2 care promote assessment at the latter level, where homes receive an automatic subsidy of \$144 per bed per month, and there is little effect on client finances one way or the other. During the past 5 years the number of Level 1 beds in the province has declined by 31%, while Level 2 beds have increased by 49%.⁶⁸

In our view, all confusion concerning funding regulations and principles of client charge determination should be overcome. Our major concern is to make a rational distinction between services which are needed because of health problems, and those which are universally required regardless of health condition. On this basis, it would appear reasonable to assess a flat rate room and board charge for all residential accommodation of \$250 per month. While this figure is somewhat arbitrary, it is not unreasonably high; more to the point, it is affordable by all senior citizens based on current guaranteed monthly income levels (July 1978):

Income Source	Married Couples	
	Single Persons	Per Person
Old Age Security	\$159.79	\$159.79
Guaranteed Income Supplement	112.08	99.52
Saskatchewan Income Plan	25.00	22.50
TOTAL	\$296.87	\$281.81

These measures should be accompanied by a mandatory assessment and placement service which will ensure proper use of facilities by those in greatest need.

We have not addressed room and board charges for Level 6 (acute) care, as the issue is of general rather than primarily geriatric concern.

Client charges for community services are similarly varied. The Saskatoon Family Service Bureau, for example, receives half its operating budget through client levies. Other organizations collect minimal client fees, while still others collect nothing. Again, there appears to be no generally applicable principle for determining the nature and size of client charges.

We are aware of certain principles regarding client charges which have been established by the provincial Home Care Directorate. Nursing services will be provided at no charge to clients. For other services, "when . . . usage exceeds \$20 in any 30-day period, an income test will be used to determine if a further charge will be levied. In general, heavy service users with below average incomes will receive a subsidy toward all or part of the cost of care. Persons with above average income will pay for the service they receive."¹⁶ Whatever charges are established for the District, in no instance should they deter senior citizens from accepting needed services or encourage institutionalization for solely financial reasons.

II. RECOMMENDATIONS

73. *The geriatrics program authority in conjunction with District institutions and provincial funding sources should develop a long range master plan for financing institutional beds, with provision for funding of short-term bed vacancies and conversion of facilities to the appropriate uses.*
74. *All duly assessed institutional residents should pay a flat rate room and board charge of \$250 per month, with all health services fully insured by the province, for Levels 1 to 4 care as presently structured in the short run, and under a revised classification system in the long run.*
75. *Client charges for community services should be rationalized, with strictly health related services fully insured, and charges assessed for ancillary services provided that rates do not inhibit senior citizens from using recommended services nor encourage institutionalization for purely financial reasons.*

III. FINANCIAL IMPLICATIONS

It is essential that the Task Force indicate the financial costs of the recommendations to give the Government an idea of the magnitude of the changes proposed. However, there are serious difficulties in ascertaining with precision current costs, long range effects of redistribution of resources and emphasis toward the community sector, and transitional costs which must be borne before ultimate benefits will be realized. While we have considerable confidence in the figures presented below, there is clearly room for some variance in interpretation, particularly where questions of definition of services and categories are involved. We are pleased that the sum total of all of the recommendations is inexpensive for both clients and the public treasury.

The figures presented in various tables should be viewed with the following caveats in mind:

1. Both current and projected client charge revenues for community based services are very rough estimates only. However, the inventory survey returns indicate that the elderly at present pay negligible amounts for most of these services.
2. The terms "transitional phase" and "start-up phase" refer to different periods of time for different program areas. For example, the start-up phase for District office functions should last perhaps two years; the transitional phase for home care may last three to five years before maximum benefits accrue; while the changeover to a new set of institutional policies may take a decade. The estimates of total expenditures during the transitional phase should not be interpreted too rigidly.
3. All institutional figures are for senior citizens only; bed and financing requirements for other groups have not been estimated. For community based and District coordinating services, the estimates include expenditures for the population at large — some 20% to 30% of the totals.
4. All figures apply to the project District only. Provincial implications in the community service sector can be estimated by multiplying by a factor of 6 to 7; in the institutional sector, by about 5. The difference results from Saskatoon being the institutional centre for a considerable number of elderly from beyond District borders.

A. Community Services

An estimated \$1.1 million is currently spent in the District for home care services, with an average caseload of roughly 400, excluding Psychiatric Home Care. It has been recommended that the program expand to handle a potential caseload of 1,300, or triple the current program size. Extrapolating from current figures, this recommendation would appear to warrant a further \$2 million annual expenditure, while

provincial policy has indicated that \$1.75 million will be the total Government funding available in the area in the immediate future (\$11 per capita).

We do not have concrete evidence of gross inefficiencies in the current system, nor a precise idea of client mix. Yet we believe that efficiencies will be achieved by rationalizing the assessment for, and delivery of, community services in conjunction with keeping administrative costs to a reasonable level. While interprovincial cost figures may not be fully comparable, it is notable that Manitoba serves about 1,000 clients on home care for each \$1 million spent. The orientation of current home care programs in the project District may partially explain higher costs, but it is hoped that economies of scale will be achieved when the expanded program is fully operational.

As a result, we are reasonably confident that a Government contribution of \$1.75 million will be sufficient in the short run for expanding community based services in accordance with demonstrated need. It is preferable to expand services gradually in a planned, logical manner instead of adding huge amounts of additional money which the current system may not be able to spend efficiently on the appropriate clientele. One might also expect that if the program expansion achieves good results, provincial per capita grants for home care will increase in response to further identified needs, with perhaps in the order of \$2.5 million total expenditures in the foreseeable future.

Included in our recommendations is the advocacy of expanded day care centers. These are facilities attached to institutions (ideally Levels 3 and 4 in the long run) where therapy and other rehabilitative services are provided to community residents. Judging from experience elsewhere, perhaps 100 Saskatoon senior citizens may be able to benefit from these services at any given time, with a third of these attending sessions on any given day. According to the recently begun project at Sherbrooke, a day center with a total capacity of 50 and a daily caseload of 16 to 18 could be operated for \$50,000 annually; with two such centers initially in Saskatoon, the total cost would be \$100,000 per year, excluding capital expenditures. As therapy services can rarely be economically delivered in the home — not to mention the shortage of O.T. and P.T. personnel — day centers should be the venues for provision of this vital aspect of comprehensive home care, approved and funded out of general home care grants. The initial capital expenditures required should be provided either by direct provincial grants in addition to home care operating funds, or through contributions from voluntary and service groups. The second center should be located on the west side of the river.

It is not anticipated that sufficient demand for day center services will be concentrated in rural centers to warrant the operation of full time facilities. As the services will normally be short term on an other than daily basis, it would appear more efficient to transport rural senior citizens to the Saskatoon centers for these services. Alternatively,

therapy aides in the rural areas could carry out some of the necessary activities under supervision from Saskatoon personnel in certain instances, with grants for mobile equipment and/or facilities in District towns where appropriate.

Senior citizen activity centers involving recreation, crafts, kitchen facilities, rest areas, greenhouses, and so on may be efficiently combined with day centers. However, these centers, although they are important and their development is encouraged, are not strictly home care components, and the home care grant should not be expected to finance their operation.

Day hospitals provide diagnostic and therapeutic services to community residents. Presumably, the establishment of these hospitals should diminish the need for outpatient services as currently delivered. The proposal for the Geriatric Assessment Unit includes a day hospital component, and we regard both developments as potentially beneficial. It is debatable whether day hospital services should be regarded as an element of home care; our inclination is that they should not, as their purpose is more related to extending inpatient services outward than to expanding community services.

B. Housing

We have recommended the revision of independent housing grant policies and public housing regulations as part of the effort to reduce the number of institutionalized senior citizens, and eliminate Levels 1 and 2 care. It is difficult to assess the cost implications of these recommendations because policy changes will be felt throughout the system. While the cost of housing will rise, the cost of institutionalization will fall. With need for services replacing financial need as the major criteria for admissions to public housing projects, client charges may rise, and Government subsidies may fall.

Based on British estimates, there should be roughly 50 sheltered housing units per thousand senior citizens, or 750 in the District. Few existing units meet all of the design criteria inherent in the sheltered housing concept, and none have all of the supervisory features.

We do not know how many of the 900 plus senior citizens housing units existing in the District would be suitable for conversion to sheltered housing. A cost of \$3,000 to \$5,000 per unit would not be unreasonable if the expenditures enabled prospective Level 1 and 2 clients to live independently. If all the proper policies could be developed and all physical structures proved suitable for conversion to sheltered housing, the total one time only cost would be roughly 750 units x \$4,000, or \$3 million. This figure appears high until it is realized that this is the cost of Level 2 care for 450 clients for one year only.

As we have suggested mainly that housing policy should be re-examined and redeveloped where necessary, we hesitate to put forth

detailed cost implications of measures not yet taken. As a general principle, cost efficiency should be a major factor in determining the nature of a new policy jointly established by at least the Saskatchewan Housing Corporation, The Department of Health, the Department of Social Services. Housing policy should promote maximum independence, which in turn means lower demands on the public treasury.

C. Levels 1-4 Institutions

The financial picture for special and extended care homes must take into account three phases: current costs, with direct and indirect subsidies; anticipated costs during the transitional phase where Levels 1 and 2 care are gradually eliminated; and long run costs once the shifts have been accomplished, and new policies have been implemented.

Savings will be achieved only in the long run; the transitional phase will in all probability not yield immediate savings. In fact, if the policy of charging a flat \$250 room and board charge for all Levels were implemented immediately, Government expenditures in the District would rise by \$660,000 annually. While this would be a defensible expenditure increase, we advocate implementing this policy carefully, and not before the new assessment and placement process is in place along with viable community based alternatives for lower levels of care.

What precisely will occur in the institutional sector during the next 5 to 10 years is difficult to determine. It is probably wise to anticipate a constant level of Level 1 to 4 expenditures for the next 3 to 5 years, based on a combination of continued Level 1 and 2 care for remaining clientele and funding of conversion plans where appropriate. Total costs to the system during the major expansion phase of community services will rise, but will fall later on when maximum preventive benefits reduce admissions to institutions. All of this assumes a constant elderly population; in reality, all expenditures will rise in the long run as the senior citizen population increases in both number and longevity.

Table 5.1 shows the implications of the recommendations if policy changes could be implemented immediately with optimum effect. Government subsidies would fall by \$310,000, clients would pay \$2,385,000 less, and total savings would be \$2,695,000. At present, the Government pays about \$513 per month per bed and clients pay about \$285 (Levels 1-4 average). With new policies, Government would pay \$782 and clients \$250 respectively, for 575 fewer beds. It should be added that the administrative costs of assessing S.A.P. subsidies and client charges would be eliminated, meaning increased savings for Government.

Table 5.2 reveals the cost implications of both current and suggested institutionalization patterns given anticipated population trends. The estimates are conservative in that the increased skewing of

**Table 5.1 — Current and Recommended Levels 1 to 4 Costs
Assuming Constant Elderly Population.**

Level of Care	Number of Beds	Total Cost	Direct Govern- ment Subsidy*	Indirect Govern- ment Subsidy**	Client Charges
1 Current	225	\$ 1,080,000	\$ 0	**	\$ †
1 Recommended	0	0	0	0	
2 Current	420	2,875,000	725,000	**	†
2 Recommended	0	0	0	0	
3 Current	800	8,785,000	4,130,000	**	†
3 Recommended	800	8,785,000	6,385,000	0	2,400,000
4 Current***	130	2,340,000	2,340,000	0	
4 Recommended	200	3,600,000	3,000,000	0	600,000
CURRENT TOTAL	1,575	\$15,080,000	\$7,195,000	\$2,500,000	\$5,385,000
RECOMMENDED TOTAL	1,000	\$12,385,000	\$9,385,000	0	\$3,000,000

* Recommended figures based on universal insurance of all costs less standard room and board charge of \$250 per month.

** Saskatchewan Assistance Plan payments, estimated, figures unavailable for each Level of care

*** Figures are approximate and include 22 beds at Sherbrooke Community Centre funded as Level 4 during 1978-9

† Difference between direct and indirect Government subsidies and total cost, breakdown by Level unavailable

the elderly population toward the 80 and over age groups has not been accounted for. If existing policies are retained, both operating and capital costs will skyrocket. The portrait for the province as a whole is particularly noteworthy when the District figures are multiplied by 5.

D. Geriatrics Program Staff and Activities

Table 5.3 indicates both current costs associated with activities which will become part of the geriatrics program, and projected expenditures based on staffing and activities recommendations. In order to keep future costs to a reasonable level, the following principles should govern implementation:

1. Projected transfers of functions and positions to the geriatrics program District office should actually take place, with new central funding offset by reductions in current system funding wherever this is feasible.
2. Provision should be made for developing certain program areas such as standards and evaluation, with funding recognition from the provincial Government in view of the overall significance of models developed in the pilot project. Where it is reasonable, positions should be seconded from the Home Care Directorate to the District office so that province wide procedures and models can be developed on a trial basis.
3. The costs of office space and equipment should be limited in that the city and/or the province should provide low cost headquarters in view of the nature of the program, and its governmental authority.

Table 5.2 — Projected Levels 1 to 4 Costs, Assuming 50% Increase in Elderly Population, With Current (8%) and Recommended (5%) Institutionalization Patterns (1978 Dollars)

Level of Care	Number of Beds	Total Cost	Government Subsidy*	Client Charges	Capital Cost of New Beds**
8%: 1	340	\$ 1,630,000	\$ 610,000	\$ 1,020,000	\$ 3,450,000
5%: 1	0	0	0	0	0
8%: 2	630	4,235,000	2,345,000	1,890,000	6,300,000
5%: 2	0	0	0	0	0
8%: 3	1,200	13,175,000	9,575,000	3,600,000	12,000,000
5%: 3	1,200	13,175,000	9,575,000	3,600,000	2,000,000
8%: 4	200	3,600,000	3,000,000	600,000	2,000,000
5%: 4	200	3,600,000	3,000,000	600,000	2,000,000
8%: TOTAL	2,370	\$22,640,000	\$15,530,000	\$7,110,000	\$23,750,000
5%: TOTAL	1,400	\$16,775,000	\$12,575,000	\$4,200,000	\$ 4,000,000

* Assumes complete insurance of care less \$250 per month universal client charge.

** 1978 estimated average cost of Levels 1-3 beds is \$30,000; of Level 4 is \$40,000.

*** Based on conversion of 400 Levels 1 and 2 beds to Level 3 @ \$5,000 per bed.

† Assumes complete conversion of Frank Eliason Centre to Level 4, plus 50 new beds.

Table 5.3 — Current and Recommended District Expenditures on Geriatrics and Related Program Activities.

Current Expenditures 1978		Recommended Expenditures	
A. Administration and Office Overhead		B. Administration and Office Overhead	
University Hospital		Geriatrics & Home Care	
Home Care Director	\$ 22,000	Program Director	\$ 28,000
Secretary to Director	13,000	Secretary to Director	13,000
Other Secretary	10,000	Administrator	23,000
Estimated Office/		Administrative Secretary/	
Supplies	12,000	Accounting Clerk	12,000
Fringe Benefits (15%)	7,000	Office/Supplies	25,000
	<u>\$ 64,000</u>	Fringe Benefits (15%)	11,000
			<u>\$112,000</u>
B. Assessment and Case Coordination		B. Assessment/Placement/Case Coord.	
1 V.O.N. Position	\$ 17,000	Director	\$ 21,000
3 University Home		Secretary/Receptionist	10,000
Care Positions	59,000	4 Public Health Nurses	68,000
3 Dept. of Social		2 Social Workers	32,000
Services Positions	48,000	1 Physiotherapist	16,000
1 Sherbrooke Community		1 Occupational Therapist	16,000
Centre Position	17,000	6 M.D. Consultants	36,000
1 Frank Eliason Centre		1 Records Secretary	10,000
Position	17,000	Other Consultants	10,000
1 Dept. of Social		Fringe Benefits	33,000
Services Secretary	10,000		<u>\$252,000</u>
Medical Assessments		C. Program Evaluation	
(contracts with institutions		Director	\$ 23,000*
& M.C.I.C. payments)	30,000	Research Officer	18,000
Fringe Benefits	30,000	1/2 Secretary	5,000*
	<u>\$228,000</u>	Data System	25,000
		Fringe Benefits	7,000
			<u>\$ 78,000</u>
C. Program Evaluation		D. Standards	
Records search,		Director	\$ 20,000*
computer time, etc.	\$ 10,000?	1/2 Secretary	5,000*
		Fringe Benefits	4,000
			<u>\$ 29,000</u>
		E. Volunteer Coordination	
		Volunteer Coordinator	\$ 15,000
		Fringe Benefits	2,000
			<u>\$ 17,000</u>
GRAND TOTAL	\$302,000	GRAND TOTAL	\$488,000

* Seconded from Home Care Directorate.

NOTE: Probable Additional Expenditures:

Grants Administration in Regina	\$ 15,000.
Other Community Service Assessment Case Coordination	20,000.
TOTAL	\$ 35,000

**Table 5.4 — Estimated Home Care Component
of Recommended District Expenditures.**

	Recommended Expenditures (1978 Dollars)	Home Care Component	Comments
A Administration/Overhead			
Geriatrics & Home Care Program Director	\$ 28,000	\$ 20,000	
Secretary to Director	13,000	9,000	All activities roughly 70% to 80% accounted for by Home Care based on anticipated expansion
Administrator	23,000	18,000	
Administrative Secretary			
Accounting Clerk	12,000	10,000	
Office Supplies	25,000	17,000	
Fringe Benefits	11,000	8,000	
	<u>\$112,000</u>	<u>\$82,000</u>	
B Assessment/Placement Case Coordination			
Director	\$ 21,000	\$ 14,000	
Secretary Receptionist	10,000	7,000	
4 Public Health Nurses	68,000	45,000	Estimates assume that roughly 1/3 of assessments will be for community service placements and 1/3 for institutions
2 Social Workers	32,000	21,000	
1 Physiotherapist	18,000	11,000	
1 Occupational Therapist	16,000	11,000	
6 M.D. Consultants	36,000	24,000	
1 Records Secretary	10,000	7,000	
Other Consultants	10,000	7,000	
Fringe Benefits	33,000	22,000	
	<u>\$252,000</u>	<u>\$169,000</u>	
C Program Evaluation			
Director	\$ 23,000	\$ 21,000	
Research Officer	18,000	9,000	Remainder for general Board of Health requirements
1/2 Secretary	5,000	3,000	
Data System	25,000	15,000	
Fringe Benefits	7,000	5,000	
	<u>\$ 78,000</u>	<u>\$ 53,000</u>	
D Standards			
Director	\$ 20,000	\$ 18,000	
1/2 Secretary	5,000	4,500	
Fringe Benefits	4,000	3,500	
	<u>\$ 29,000</u>	<u>\$ 26,000</u>	
E Volunteer Coordination			
Volunteer Coordinator	\$ 15,000	\$ 9,500	Remainder for institutional activities, etc.
Fringe Benefits	2,000	1,500	
	<u>\$ 17,000</u>	<u>\$ 11,000</u>	
GRAND TOTAL	\$488,000	\$341,000	
After start-up phase subtract			
F Seconded Positions			
Evaluation Director	\$ 23,000	\$ 21,000	
Standards Director	20,000	18,000	
1 Secretary	10,000	7,500	
Fringe Benefits	8,000	7,000	
	<u>\$ 61,000</u>	<u>\$ 53,500</u>	
which leaves long term			
GRAND TOTAL	\$427,000	\$287,500	\$139,500 recommended for non- home care activities

The following details should be borne in mind in looking at the current costs and recommended increases:

1. Current estimates are deliberately understated where actual shifts in positions are not seen as ultimately possible. For example, institutional personnel perform Levels 1-4 assessments throughout the system, not merely in Sherbrooke and Frank Eliason Centres. Considering that some 1,200 other beds are involved, no doubt at least \$50,000 is spent on this activity. While positions might not be shifted, it must be assumed that Directors of Nursing and other personnel who will no longer have to do detailed assessments — often duplicated — will be free to emphasize other duties, with resultant, if not highly visible benefits.
2. The positions marked with an asterisk should be funded by Regina, as the standards setting and evaluation activities will apply throughout the province once models are developed. When the developmental phase is over in one to two years, the positions will not exist locally, and their functions will be transferred to other District office personnel. Thus the projected geriatrics program costs to be funded locally are \$427,000, an increase of \$125,000.
3. Of the projected net local expenditures of \$427,000, a total of \$287,500 will be directly accounted for by home care (see Table 5.4). Thus \$139,500 is the recommended increase for additional geriatrics program functions such as institutional assessment and placement, evaluation of related programs governed by the Board of Health, computerizing other programs' information systems, administering service contracts, etc.
4. Community agencies which will no longer have to carry out detailed assessments and referral and information functions should presumably be able to devote more time to direct service provision. Savings should therefore be realized when service contracts reflect lower overhead and lower unit costs among these agencies.
5. \$24,000 of the increase is for expanded and rationalized assessment and placement. The District Unit should be able to perhaps double the number of assessments of discrete cases and improve the accuracy of assessment and placement, with a view to effecting substantial reductions in Level 1 and 2 admissions, and possibly some Level 3. *Savings in Levels 1-4 expenditures can only come about if these additional assessment expenditures are made.*
6. The program evaluation and monitoring costs are necessary so that the allocation of resources throughout the service system will be matched with clearly identified and monitored need. As home care will be expanding, it is essential that new service needs be accurately identified and quantified, and results of service intervention made visible.

In sum, the new expenditures are recommended to administer an expanding community services network with up to triple the current caseload, and coordinate the assessment and placement of clients across the continuum of services extending from basic home care through to Level 4, and including public housing, day hospitals, day care, and other innovative programs. The current system is fragmented and institutionally oriented. By spending additional funds on a new coordinating structure, the lengthy and difficult process of identifying existing service performance and gaps and shifting emphasis to the community sector can be begun.

Table 5.5 summarizes the financial implications of all recommendations, excluding housing for the reasons stated above. Figures are estimated for the transitional phase during which the shifting process will be initiated. It must be stated that the transitional costs are presented optimistically; during the first few years, institutional costs may remain at or near existing levels, in which case the total costs could reach \$19 million during the most "inefficient" changeover phase. This is more than balanced by the savings outlined in Table 5.2 regarding pre-empted new capital costs for additional beds.

Table 5.5 should be read as follows:

1. The Home Care Grant will pay for only part of the District office activities, as explained in Table 5.4.
2. The Provincial Geriatrics Program Pilot Project Grant of \$140,000 in the transitional phase will cover the additional District costs of non-geriatric and/or non-home care activities. In the long term this amount will come out of general Board of Health revenues.

Finally, Table 5.6 describes the anticipated benefits accruing from the development of District office functions. We think that rather reasonable new expenditures will allow the first comprehensive attempt to rationalize and integrate the service system. There are no guarantees that all the desired results of the pilot project will be achieved, for the task is enormous and complex. Nevertheless, we are convinced that the endeavour is necessary, and that the potential benefits — both financial and in terms of quality of service — more than justify the recommended measures.

Table 5.5 — Current, Transitional and Long-Term Funding Sources for Geriatrics Program and Related Activities Assuming Constant Elderly Population and 1978 Dollars.

Funding Source	Current	Transitional	Long Term
Provincial Home Care Grant via Board of Health: *			
District Office Admin.	\$ 64,000	\$ 82,000	\$ 82,000
Assessment/Placement.	154,000	169,000	169,000
Program Evaluation.	10,000	25,000	25,000
Volunteer Coordinator.	0	11,000	11,000
Contracted Services.	870,000	1,450,000	2,000,000?
Day Centre Operations.	25,000	50,000	100,000
Secondments Funded by Provincial Home Care Directorate:			
Program Evaluation.	0	32,000	0
Standards.	0	29,000	0
Provincial Geriatrics Program Pilot Project Grant.	74,000**	140,000	0
Board of Health General Funding of Program Functions.			
	0	0	140,000
Direct Provincial Subsidy of Levels 1 to 4 Care.	7,195,000	rising to 9,385,000	9,385,000
Saskatchewan Assistance Plan Payments to 1 to 4 Clients.	2,500,000	falling to 0	0
Client Charges: Levels 1 to 4.	5,385,000	falling to 3,000,000	3,000,000
Home Care/Day Care.	?	200,000	300,000
S.H.S.P. Funding of Geriatric Assessment Unit/Day Hospital.			
	0	780,000	780,000
TOTAL.			
	\$16,277,000	falling to \$15,353,000	\$15,992,000

* Current costs not funded through Board of Health, but directly to agencies and institutions by the provincial Government.

** This is the amount of provincial money now spent on assessment activities related to institutions.

Table 5.6 — Comparison of Current and Recommended Activities in Five Functional Geriatrics Program Areas

Current Activities	Recommended Activities
A. Administration	A. District Office Administration
— no coordination of funding of service organizations — indirect provincial administration of roughly \$1.1 million for home care services — no advisory role with respect to institutional expenditures	— systematic contracting of services with monitoring of efficiency — direct local administration of roughly \$2.4 million for community services — formal advisory role with respect to institutional expenditures
B. Assessment/Placement/Coordination	B. Assessment/Placement/Case Co-ordination
— perhaps 1,000 assessments annually — no systematic approach or procedures for assessments — institutionally assessed clients rarely considered for community service alternatives — multidisciplinary assessments only where service organization has this capacity — placement in programs dependent on type of initial contact with service system and/or perceived needs of clients, families, and service organizations — no coordinated waiting lists for Levels 1 to 3 institutional care or community service programs — no systemic procedure for serving clients in order of priority of need — clients served by two or more agencies do not necessarily have case co-ordinator	— capacity for 2,000 assessments annually — uniform assessment procedures — automatic consideration of all assessed clients for community services wherever feasible — guaranteed multidisciplinary assessment where needed — placement carefully matched to client needs based on uniform assessment — District coordination of waiting lists for all programs — guaranteed provision of service to clients in order of priority of need based on standardized assessment — assessment personnel automatically act in case coordination capacity
C. Program Evaluation	C. Program Evaluation
— no relation of organization performance to clearly enunciated systemic goals — evaluation generally done by Agency Boards using own criteria — no comparative evaluations of agencies or institutions — data collection non-standardized, often non-existent for evaluative purposes — mainly intuitive perception of systemic gaps and inappropriately balanced allocation of resources	— clear definition of goals of system and relation of performance to these goals — system wide evaluation using standard criteria; Boards will continue to do internal evaluations as desired — routine comparative evaluations based on clearly enunciated criteria — standard, computerized data system for all organizations with easy retrieval and analysis — revelation of systemic service gaps and need for redistribution of resources based on data analysis related to the assessment process

D. Program Standards

- only implied in some instances
- non-standardized among community services
- very basic in institutions, with no mandatory recognition of changing service needs with emphasis on rehabilitation
- no formal statement of standards of economic efficiency

E. Voluntarism

- developed primarily in institutions with no inter-agency coordination
- no systemic policies for increased development of voluntarism and/or expanded activity areas

D. Program Standards

- explicit in all cases
- standardized for all community services
- comprehensive in institutions with renewed emphasis on rehabilitation and related to clearly defined program goals
- formal administrative and unit of service cost standards

E. Voluntarism

- District Coordinator to emphasize community service voluntarism and inter-agency communications
 - policies to be developed for systematically expanding potential of voluntarism to its optimal level of activity
-

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While time constraints and the nature of the project precluded the Task Force from undertaking a full scale research study, the secretariat was able to obtain and examine a considerable range of documents, some of which were submitted specifically to members, and others of more general relevance to senior citizens' services.

This selected bibliography both recognizes and documents the material submitted by the Panel of Experts and others for use by the Task Force, and refers to other material which proved of direct or indirect value in drafting the final report. While it was obviously impossible to include detailed discussions of the wealth of ideas and statistics contained in the references listed, we feel that it is useful to indicate the range of expertise from which some thoughts and conclusions have emanated, particularly for those who might be interested in doing further research in the area of geriatrics program planning. We hasten to add, however, that this bibliography is in no way definitive, and only begins to scratch the surface of what is fast becoming a very large field.

The items are numbered to correspond to references in the text of the report.

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APPENDIX 1. TERMS OF REFERENCE

APPENDIX 1

TERMS OF REFERENCE

Preamble:

The Report of the Committee on Service Funding of the College of Medicine, University of Saskatchewan recommended that the Ministers of Health and Social Services establish a Task Force to develop a program proposal for a demonstration community based comprehensive geriatric program for Saskatoon City and the rural area adjacent. The context for the establishment of the Committee and the demonstration project are found in the Report of the Service Funding Committee.

In the fiscal context, the Committee stated "while it is appreciated that seed money will be required to allow a start to be made on such a program it is anticipated that with the emphasis on community services and through the more effective use of these and institutional resources that budget implications will be essentially ones of "shifts" rather than "add ons" bearing in mind and adjusting for changes of numbers of elderly persons."

Within the context stated or implied in the Service Funding Report, and within the fiscal restraint identified above, the Terms of Reference of the Ministerial Task Force are as follows:

- 1) To develop a program proposal to the Provincial Government for a demonstration community based program of services for senior citizens in Saskatoon City and the rural area adjacent. Specific attention in the program proposal should be devoted to:
 - a) Recommending the mix and types of service which need to be included, with particular attention on those services which presently exist in the community.
 - b) Recommending staffing and facilities required to implement the recommendations.
 - c) Estimating the costs of the proposal.
 - d) Priorizing the recommendations and suggesting strategies for their staged implementation.
- 2) Take account of the clinical resources which will be needed by the newly approved Division of Geriatric Medicine of the College of Medicine, University of Saskatchewan, and identify the clinical resources which are in existence.
- 3) List the community resources and services which exist in Saskatoon and the rural area which should contribute to the demonstration project.

Indicate the approximate amount of service which could be contributed to the project from these existing programs and suggest the mechanisms which will be needed to coordinate this contribution.

- 4) Make recommendations as necessary to give effect to the proposal, but specifically comment on:
 - a) The organizational arrangements which are needed to implement the demonstration project.
 - b) The legal mandate which might be needed to implement the project.
 - c) The phasing of the implementation of the proposal.
 - d) The cost of the project for fiscal 1978-79.
 - e) The location of the service sites.
- 5) The Task Force should report to the Ministers of Health and Social Services not later than September 1st, 1978.

Membership on the Task Force:

Membership on the Task Force has been selected to reflect an exclusive Saskatoon area orientation. The membership possesses a variety of professional orientations and abilities but is not intended to possess recognized expertise in the area of geriatric medicine. Expertise, as required, will be drawn by the Committee from consultants. The Task Force is empowered to add expertise to the consultants group at its own discretion.

Task Force Membership:

CHAIRMAN — Mr. Elmer Schwartz
VICE-CHAIRMAN — Dr. Fred Gathercole
Mr. Wayne Fyffe
Mr. Phil Gaudet
Dean Hester Kernen
Dean R. G. Murray
Mr. Ed Marleau
Dr. Bryan Dawson
Mr. Ted Cardwell
Mrs. Magdalen Dagenais (Humboldt)

Secretary and Research Director to the Task Force:

Mr. Steven Lewis

Consultants to the Task Force:

Mr. Harry Mullens, Chairman, Senior Citizens Provincial Council
Dr. S. L. Skoll, Provincial Gerontologist

Dr. T. E. Hunt, Professor of Rehabilitation & Geriatric Medicine, University of Saskatchewan, Saskatoon

Dr. W. Hatswell, Medical Consultant for the Department of Social Services

Mrs. Jean Innes, Associate Professor of Nursing, College of Nursing, University of Saskatchewan, Saskatoon

Added by the Task Force:

Dr. G. Piper, Medical Health Officer, Saskatoon Rural Health Region

Miss Muriel Jarvis, Director of Personnel, Sherbrooke Community Centre

Dr. C. M. Smith, Consultant, Mental Health Services for the Elderly, Saskatchewan Department of Health

**APPENDIX 2A. SENIOR CITIZENS'
SERVICES INVENTORY
QUESTIONNAIRE**

APPENDIX 2A.

SENIOR CITIZENS' SERVICES INVENTORY QUESTIONNAIRE

Please return to: **BY APRIL 5**

Steven Lewis

c/o Executive Director

City Hospital

SASKATOON, Sask. S7K 0M7

Questionnaire No.

(Do not complete)

1 ☐ ☐ ☐

SENIOR CITIZENS' SERVICES INVENTORY QUESTIONNAIRE

1. Name of agency _____

2. Type of agency 1 Government
2 Private 3 Voluntary 4 other
(specify)

SEE MANUAL.....

4 ☐

3. Type of services to senior citizens
(65+)

1 institutional — to residents
of Levels 1 to 6

2 community-based — to
people in own residence
where no special care is
internally provided_____%

5 ☐

3 both: institutional_____ %
community _____%

4. Area served by your in-
stitution/branch/office: SEE
MANUAL

1 Saskatoon & immediate
surrounding area

2 Saskatoon & up to 30 miles
radius

3 Saskatoon & 30-plus mile
radius

4 Town/village/hamlet/rural
municipality only

5 Town/village/hamlet/RM &
up to 30 mile radius

6 ☐

6 Rural center and 30-plus
mile radius

- 7 Saskatoon Rural Health
Region
8 Northern part of province
9 Other (specify) _____

5. Annual budget: SEE MANUAL

- a. Total annual budget (to nearest dollar) of your institution/branch/office 7 \$ □□ □□□ □□□
- b. Total annual budget of your institution/branch/office, INCLUDING services CONTRACTED FROM other agencies but EXCLUDING services CONTRACTED TO other agencies 15 \$ □□ □□□ □□□
- c. Breakdown of b. into
Budget for institutional services 23 \$ □□ □□□ □□□
Budget for community-based services 31 \$ □ □□□ □□□

6. Funding sources and amounts from each (to nearest dollar)

- Federal government 38 \$ □□□ □□□
- Provincial government 44 \$ □□ □□□ □□□
- Local/municipal government 52 \$ □ □□□ □□□
- United appeal — local and/or other 59 \$ □□□ □□□
- Campaigns 65 \$ □□□ □□□
- Client charges 71 \$ □ □□□ □□□
- Services contracted to other agencies 78 \$ □□□ □□□
- Special grants 84 \$ □□□ □□□
- Donations 90 \$ □□□ □□□
- Bequests 96 \$ □□□ □□□
- Membership fees 102 \$ □□□ □□□
- Dinners, raffles, other special activities 108 \$ □□□ □□□
- Other (specify) _____ 114 \$ □□□ □□□
- Source unknown 120 \$ □□□ □□□
- TOTAL — should equal response to 5a. 126 \$ □□ □□□ □□□

7. Actual or estimated annual budget for administration and provision of services TO SENIOR CITIZENS, EXCLUDING services CONTRACTED TO other agencies but INCLUDING services CONTRACTED FROM other agencies 134 \$

a. Value of services CONTRACTED FROM agencies 142 \$

b. Value of services CONTRACTED TO agencies 148 \$

8. **BREAKDOWN OF SERVICES TO SENIOR CITIZENS: SEE MANUAL**

a. Value of services to Levels 1-6 residents 154 \$

Value of services to people in community 162 \$

b. Value of services to Saskatoon residents SEE MANUAL FOR DEFINITION 169 \$

Value of services to rural residents 176 \$

9. **ORGANIZATIONAL STRUCTURES AND AUTHORITY**

- 01 Parent org. Board of Directors
- 02 National Board of Directors
- 03 Interprovincial Board of Directors
- 04 Provincial Board of Directors
- 05 Regional/District Board of Directors
- 06 Local Board of Directors
- 07 Provincial Department of Health
- 08 Provincial Dept. of Social Services
- 09 Other Provincial Department
- 10 Saskatoon City Council/Board of Health
- 11 Local government Council/Board
- 12 Saskatoon Rural Regional Board
- 13 National Executive Director
- 14 Interprovincial Executive Director
- 15 Provincial Executive Director

- 16 Regional/District Exec. Director
- 17 Local Executive Director
- 18 Staff Supervisor(s)
- 19 Staff
- 20 Professional Association
- 21 Other
- 22 Not Applicable

From the above list insert the **number** of the structure/person both **formally** and **actually** responsible for the activities below. FOR DEFINITIONS OF THE LIST AND THE DISTINCTION BETWEEN FORMAL AND ACTUAL RESPONSIBILITY, PLEASE SEE MANUAL.

Activity	Structure/ Person Formally Responsible	Structure/ Person Actually Responsible
a. Preparing local budget submission	183 ☐ ☐	185 ☐ ☐
b. Approving local budget	187 ☐ ☐	189 ☐ ☐
c. Conducting fund-raising, etc.	191 ☐ ☐	193 ☐ ☐
d. Determining services offered	195 ☐ ☐	197 ☐ ☐
e. Determining type of staff hired	199 ☐ ☐	201 ☐ ☐
f. Determining client eligibility	203 ☐ ☐	205 ☐ ☐
g. Setting/changing service standards	207 ☐ ☐	209 ☐ ☐
h. Hiring/firing local staff	211 ☐ ☐	213 ☐ ☐
i. Evaluating local program(s)	215 ☐ ☐	217 ☐ ☐
j. Referring clients to other agencies	219 ☐ ☐	221 ☐ ☐
k. Coordinating cases with other agencies	223 ☐ ☐	225 ☐ ☐
l. Contracting services to/from agencies	227 ☐ ☐	229 ☐ ☐

10. PROGRAM DETAILS: 65 AND OVER CLIENTS ONLY

a. No. male elderly clients served annually	231 ☐ ☐ ☐ ☐
No. female elderly clients served annually	235 ☐ ☐ ☐ ☐
Total elderly clients served annually	239 ☐ ☐ ☐ ☐

- b. No. **male** elderly currently on caseload 243 ☐☐☐☐
 No. **female** elderly currently on caseload 247 ☐☐☐☐
Total elderly currently on caseload 251 ☐☐☐☐
- c. Average no. of weeks on caseload — **males** (SEE MANUAL) 255 ☐☐☐
 Average no. of weeks on caseload — **females** 258 ☐☐☐
 Average no. of weeks on caseload — **total** 261 ☐☐☐
- d. Total annual cost of services to **male** elderly — SHOULD BE PROPORTION OF AMOUNT INDICATED FOR QUESTION (7)
 264 \$ ☐ ☐☐☐ ☐☐
 Total annual cost of services to female elderly
 271 \$ ☐ ☐☐☐ ☐☐
 Total annual cost of services to elderly — SHOULD EQUAL RESPONSE TO QUESTION (7) 278 \$ ☐☐ ☐☐☐☐
- e. Average cost per elderly **male** client per year 286 \$ ☐☐ ☐☐☐
 Average cost per elderly **female** client per year 291 \$ ☐☐ ☐☐☐
 Average cost, all elderly clients, per year 296 \$ ☐☐ ☐☐☐

Indicate the MAJOR PURPOSES of your program(s) for the elderly from the list below. Use numerical codes

- 1 Yes
 2 No

SEE MANUAL FOR EXPLANATIONS

- f. Maintain client in independent residence 301 ☐
 g. Stabilize or improve medical/physical condition 302 ☐

h. Stabilize or improve emotional/mental condition	303	☐
i. Relieve cohabitants of some of burden of care	304	☐
j. Improve client ability to perform activities of daily living	305	☐
k. Provide recreation/entertainment/stimulation program	306	☐
l. Provide required care in institutional setting	307	☐
m. Shorten acute care hospital stay	308	☐
n. Shorten Levels 1-4 special care/nursing home stay	309	☐
o. Improve client's material/-financial circumstances	310	☐
p. Structurally improve client's physical environment	311	☐
q. Provide education/referral advice to client	312	☐
r. Play advocacy role for elderly in general	313	☐
s. Other _____	314	☐

Indicate from the list below the description that most closely fits the hours during which your institution/branch/office offers part or all of its services.

- 1 Monday to Friday, regular office hours
- 2 Monday to Friday, regular office hours & evenings
- 3 Monday to Friday, 24 hours a day
- 4 Monday to Friday, reg. office hours & part of weekend
- 5 Regular hours, 7 days a week
- 6 Twenty-four hours a day, 7 days a week

- 7 Regular office hours & evenings, 7 days a week
- 8 Part-time, less than regular working week
- 9 Other (specify) _____
- t. Actual delivery of major services to elderly 315 ☐
- u. Phone-in/counselling/other communication system 316 ☐

11. RESULTS OF PROGRAMS

Describe the **outcome** of your services by indicating the percentage of elderly clients to which the following statements apply (65+ age group ONLY): SEE MANUAL.

Use the following coding for this and other specified sections of the questionnaire:

01: 0- 9% 04: 30-39% 07: 60-69% 10: 90-100%
 02: 10-19% 05: 40-49% 08: 70-79%
 03: 20-29% 06: 50-59% 09: 80-89%

- a. Medical/physical condition improved/stabilized 317 ☐
- b. Emotional/mental condition improved/stabilized 319 ☐
- c. Client improves until services no longer required 321 ☐
- d. Client stabilizes with need for stable level of services 323 ☐
- e. Client deteriorates with increased need for services 325 ☐
- f. Admission to acute care hospital prevented/delayed 327 ☐
- g. Admission to Level 1-4 institution prevented/delayed 329 ☐
- h. Earlier discharge from acute care hospital made possible 331 ☐
- i. Earlier discharge from Level 1-4 institution made possible 333 ☐
- j. Client referred to appropriate service organization 335 ☐
- k. Other (specify) _____ 337 ☐

Indicate the **percentage** (using coding as above) of clients 65 and over discharged from your program(s) annually who leave the caseload for each of the following reasons: SEE MANUAL

- l. Client deceased 339 ☐

- | | | |
|---|-----|---|
| m. Client moves out of service area
(but not to institution) | 341 | ☐ ☐ |
| n. Client enters acute care
hospital | 343 | ☐ ☐ |
| o. Client enters Level 1-4 in-
stitution | 345 | ☐ ☐ |
| p. Client improves, no longer
needs services | 347 | ☐ ☐ |
| q. Client deteriorates, home
service needs become too
great | 349 | ☐ ☐ |
| r. Client requests services be
terminated | 351 | ☐ ☐ |
| s. Client can no longer afford
service charge | 353 | ☐ ☐ |
| t. Other (specify) _____ | 355 | ☐ ☐ |

12. **CLIENT ASSESSMENT DETAILS:**
SEE MANUAL

Type of Personnel		No. Assessed Annually	No. Served Annually
Nurses	357	☐ ☐ ☐ ☐	361 ☐ ☐ ☐ ☐
Social Workers	365	☐ ☐ ☐ ☐	369 ☐ ☐ ☐ ☐
Physicians	373	☐ ☐ ☐ ☐	377 ☐ ☐ ☐ ☐
Physiotherapists	381	☐ ☐ ☐ ☐	385 ☐ ☐ ☐ ☐
Occupational Therapists	389	☐ ☐ ☐ ☐	393 ☐ ☐ ☐ ☐
Office/Administrative Staff	397	☐ ☐ ☐ ☐	401 ☐ ☐ ☐ ☐
Volunteers	405	☐ ☐ ☐ ☐	409 ☐ ☐ ☐ ☐
Other (specify) _____	413	☐ ☐ ☐ ☐	417 ☐ ☐ ☐ ☐
TOTALS	421	☐ ☐ ☐ ☐	426 ☐ ☐ ☐ ☐

- | | | |
|---|-----|---|
| a. No. of elderly clients
presented to your agency
annually who have been
assessed by personnel outside
your agency | 430 | ☐ ☐ ☐ ☐ |
| b. No. of these externally
assessed elderly clients:
Not accepted on your
caseload | 434 | ☐ ☐ ☐ ☐ |
| Accepted on caseload with
reassessment by your agency | 438 | ☐ ☐ ☐ ☐ |
| Accepted without
reassessment by your agency | 442 | ☐ ☐ ☐ ☐ |
| c. Do you use a standard written
assessment form? 1 Yes
If yes, please provide copy.
2 No | 446 | ☐ |
| d. Of the elderly assessed by
your agency, indicate below
the percentage of clients who | | |

6. SEE MANUAL

Indicate which of the following conditions **must** be presented for a client to be eligible for your services — can be more than one per client. SEE MANUAL.

Code	1 Yes
	2 No

484 □

485 □

486 □

487 ☐488 ☐489 ☐490 ☐491 ☐

n. Client does not need services

492 □□

- | | | | |
|--|-----|--------------------------|--------------------------|
| o. Agency not most suitable for client's needs | 494 | ☐ | ☐ |
| p. Agency unable to accept new clients — caseload at capacity | 496 | ☐ | ☐ |
| q. Agency unable to provide intensity of services required
SEE MANUAL | 498 | ☐ | ☐ |
| r. Client does not require defined minimum level of service | 500 | ☐ | ☐ |
| s. Client unable to pay for services | 502 | ☐ | ☐ |
| t. Client refuses services offered after assessment | 504 | ☐ | ☐ |
| u. Other (specify) _____ | 506 | ☐ | ☐ |

13. EXISTING COMMUNICATIONS

- List the institutions/agencies/offices, local or otherwise, with whom you have formal affiliation — that is, legal affiliation, line authority structures, shared Board of Directors, shared staff, etc.
- List the institutions/agencies with which your organization officially coordinates services, assessment of clients, program standards and/or procedures, budget requests, etc.
- Give details of your referral patterns of clients 65 and over
ONLY: SEE MANUAL

Agency/Inst./Individual/Group	No. Referred Annually TO your organization		No. Referred Annually FROM your organization	
Physicians	508	☐ ☐ ☐ ☐	512	☐ ☐ ☐ ☐
Acute care hospitals	516	☐ ☐ ☐ ☐	520	☐ ☐ ☐ ☐
Levels 1-4 institutions	524	☐ ☐ ☐ ☐	528	☐ ☐ ☐ ☐
Family/friends/neighbors	532	☐ ☐ ☐ ☐	536	☐ ☐ ☐ ☐
Community service agencies	540	☐ ☐ ☐ ☐	544	☐ ☐ ☐ ☐
Other institutional organizations	548	☐ ☐ ☐ ☐	552	☐ ☐ ☐ ☐
Saskatoon City Health Dept.	556	☐ ☐ ☐ ☐	560	☐ ☐ ☐ ☐
Saskatoon Rural Health Region	564	☐ ☐ ☐ ☐	568	☐ ☐ ☐ ☐
Other (specify) _____	572	☐ ☐ ☐ ☐	576	☐ ☐ ☐ ☐
TOTALS	580	☐ ☐ ☐ ☐	584	☐ ☐ ☐ ☐

- List organizations with which you have unofficial/informal contact regarding program planning and coordination of services to the elderly:

14. ASSESSMENT OF EXISTING PROGRAMS FOR SENIOR CITIZENS

This section is designed to solicit your opinions of how the present community service system operates. Two evaluations are requested: first, an assessment of how you feel your own organization now operates in the areas listed below; and second, an indication of how well the system as a whole is functioning in

these areas. You may wish to base your assessments on whatever concrete information you have at your disposal; however, we are also interested in receiving opinions based on general perceptions of the performance of existing services. Use the coding system as follows:

- 1 Excellent 2 Good 3 Fair 4 Poor
5 No opinion 6 Not applicable

Program Aspect	Performance of Own Agency	Performance of Overall System
a. General administrative efficiency	588 ☐	589 ☐
b. Range of services offered	590 ☐	591 ☐
c. Volume of services provided relative to need	592 ☐	593 ☐
d. Client assessment mechanisms	594 ☐	595 ☐
e. Interagency referral mechanisms	596 ☐	597 ☐
f. Planning within agencies	598 ☐	599 ☐
g. Planning with other agencies	600 ☐	601 ☐
h. Recruitment of appropriate staff	602 ☐	603 ☐
i. Orientation of staff toward elderly	604 ☐	605 ☐
j. Matching staff training with duties	606 ☐	607 ☐
k. Standards of service delivery/care	608 ☐	609 ☐
l. Coordination of service standards	610 ☐	611 ☐
m. Priorizing client needs and waiting lists	612 ☐	613 ☐
n. Program evaluation	614 ☐	615 ☐
o. Publicizing availability of services	616 ☐	617 ☐
p. Ease of access to services — elimination of financial and other barriers	618 ☐	619 ☐
q. Placement of clients with most appropriate service agency/institution	620 ☐	621 ☐
r. Speed of response to identified needs	622 ☐	623 ☐

15. POTENTIAL FOR PLANNING AND COORDINATION

This section is designed to solicit your opinions on **purely hypothetical** organizational arrangements for services to senior citizens. We want to know your views on two aspects: first, the likelihood of your organization being willing to participate in the listed systems; and second, your assessment of the likelihood of

the community service system as a whole achieving the level of coordination implicit in the hypothetical measures. Use the coding system as follows:

- 1 Excellent 2 Good 3 Fair 4 Poor
5 No opinion 6 Not applicable

Hypothetical Measure	Likelihood of Own Agency Participating	Likelihood of System Achieving
a. Uniform client assessment	624 ☐	625 ☐
b. Uniform program delivery standards	626 ☐	627 ☐
c. Central record keeping system	628 ☐	629 ☐
d. Centralized client referrals	630 ☐	631 ☐
e. Centralized case coordination	632 ☐	633 ☐
f. Coordinated staff hiring	634 ☐	635 ☐
g. Coordinated staff deployment	636 ☐	637 ☐
h. Coordinated communication with government	638 ☐	639 ☐
i. Amalgamation of organizations providing identical services	640 ☐	641 ☐
j. Coordinated geriatric education	642 ☐	643 ☐
k. Involvement of physicians in client assessment and referral	644 ☐	645 ☐
l. Full integration of hospital/special care home/community service system	646 ☐	647 ☐
m. Coordinated screening high risk elderly	648 ☐	649 ☐
n. Coordinated program evaluation	650 ☐	651 ☐
o. Centralized prioritization of client needs and waiting lists	652 ☐	653 ☐

16. List IN ORDER OF PRIORITY up to (but not necessarily) 5 services which the community — that is, the city/town/district in which you operate — MOST URGENTLY needs to overcome existing gaps and deficiencies in programs. You may list administrative as well as direct client services if you feel this is a priority. Also indicate whether this would be a NEW SERVICE or an EXPANDED EXISTING SERVICE in your area.

Type of Service Needed	(Leave Blank)	1 New Service	2 Expanded Service
1. _____	654 ☐	656 ☐	
2. _____	657 ☐	659 ☐	
3. _____	660 ☐	662 ☐	
4. _____	663 ☐	665 ☐	
5. _____	666 ☐	668 ☐	

ADDITIONAL COMMENTS:

17. STAFF AND ACTIVITIES: 65 AND OVER CLIENTS ONLY

Indicate on the following chart the **services to the elderly** provided by personnel either hired directly by your agency or contracted **from** another agency. **Do not include** personnel which your agency contracts **out** to another agency.

The purposes of this chart are to provide information on the proportion of total service that is devoted to the elderly, the types of service and personnel who provide them. Do this by indicating how many full-time equivalent staff are devoted annually to the administration and provision of services to the elderly. (A full-time position is approximately 1,800 hours per year).

For each personnel category you will need to determine how many full-time positions (in decimals to the nearest tenth — e.g. .9 positions, 1.5 positions) their services to the elderly comprise. This amount is then divided across the applicable activities according to the proportion of time spent on them. (If you total the amounts under activities for each personnel category it should equal the amount you calculated for total positions).

EXAMPLE:

If, in your agency, you have 4 full-time nursing positions (B.S.N.) you may calculate that of these there is .9 total positions in nursing providing services for the elderly. Then you may calculate further that of this .9 position .1 of the time is spent in administration, .2 in assessment, .3 in direct nursing care, .1 in casefinding, .1 in personal care and hygiene, and .1 in counselling.

If you total the activities you find they will add up to .9 (the total position).

$$.1 + .2 + .3 + .1 + .1 + .1 = .9$$

This kind of calculation is done for all personnel in your agency that provide services to the elderly.

REFER TO THE INSTRUCTION MANUAL for clarification of the activities.

If you CANNOT make these calculations or feel that the chart is not applicable to your agency please provide the information by: listing all your personnel, the specific activities they perform for the elderly and how much of their time is taken up doing this.

18. SERVICES OFFERED AND ANNUAL CASELOADS

Indicate the number of clients who received each of the following services from your agency in the last year for which information is available. Include services **contracted from** other agencies; do not include services **contracted to** other agencies.

Service	No. of Elderly Served Annually
Nursing	669
Homemaking	673
Meals-On-Wheels	677
Physiotherapy	681
Occupational Therapy	685
Speech Therapy	689
Psychiatric Services	693
Other Physician Services	697
Transportation	701
Home Repairs, etc.	705
Friendly Visits	709
Recreation/Entertainment	713
Social Work	717
TOTAL	721

19. INFORMATION ON LEVELS 1-4 INSTITUTIONS ONLY

a. No. Level 1 beds	725
b. No. Level 1 beds occupied by senior citizens (65 +)	728
c. No. Level 2 beds	731
d. No. Level 2 beds occupied by senior citizens	734
e. No. Level 3 beds	737
f. No. Level 3 beds occupied by senior citizens	740
g. No. Level 4 beds	743
h. No. Level 4 beds occupied by senior citizens	746

- | | | | | | | | |
|--|-----|--------------------------|--------------------------|--------------------------|--------------------------|--------------------------|------------------------------|
| i. Total annual cost Level 1 care | 749 | ☐ | ☐ | ☐ | ☐ | ☐ | ☐ |
| j. Total annual cost Level 2 care | 756 | ☐ | ☐ | ☐ | ☐ | ☐ | ☐ |
| k. Total annual cost Level 3 care | 763 | ☐ | ☐ | ☐ | ☐ | ☐ | ☐ |
| l. Total annual cost Level 4 care | 770 | ☐ | ☐ | ☐ | ☐ | ☐ | ☐ |
| m. Your institution is 1 In Saskatoon
2 Outside Saskatoon | | | | | | | |
| | | | | | | | 777 ☐ |

20. **INFORMATION ON SHELTERED HOUSING PROJECTS ONLY:**
SEE MANUAL FOR DEFINITION

- | | | | | |
|--|-----|--------------------------|--------------------------|--------------------------|
| a. No. of self-contained units —
own kitchen & bathroom | 778 | ☐ | ☐ | ☐ |
| b. No. of self-contained units
occupied by sr. citizens | 781 | ☐ | ☐ | ☐ |
| c. No. senior citizens (total) in self-
contained units | 784 | ☐ | ☐ | ☐ |
| d. Average cost of each self-
contained unit when built | 787 | ☐ | ☐ | ☐ |
| e. No. units without kitchen and/or
bathroom | 792 | ☐ | ☐ | ☐ |
| f. No. of these units occupied by
senior citizens | 795 | ☐ | ☐ | ☐ |
| g. No. senior citizens (total) in
these units | 798 | ☐ | ☐ | ☐ |
| h. Average cost of each
"dependent" unit when built | 801 | ☐ | ☐ | ☐ |
| The following questions are to
be answered either 1 Yes or 2
No | | | | |
| i. Are most or all en-
trances/doorways wheelchair
accessible? | 806 | ☐ | | |
| j. Are most or all hallways
equipped with handrails? | 807 | ☐ | | |
| k. Are most or all bathrooms
equipped with bathtub rails,
raised toilet seats, etc.? | 808 | ☐ | | |
| l. Are most or all kitchens
equipped with stoves, sinks,
cupboards, etc. accessible to
people confined to
wheelchairs? | 809 | ☐ | | |
| m. Is it your policy to modify ac-
commodations for wheelchairs
and other disabilities wherever
feasible? | 810 | ☐ | | |
| n. Is there a formal surveillance
system whereby residents are
routinely "looked in on" or
phoned at regular intervals? | 811 | ☐ | | |

- o. Can residents take meals in a common eating area — is there a regular meal service available on the premises?

812 ☐

21. **INFORMATION ON ACUTE CARE HOSPITALS (LEVEL 6) ONLY:**
SEE MANUAL

- | | |
|---|--|
| a. Rated bed capacity Level 6 in 1977 | 813 ☐ ☐ ☐ ☐ |
| b. Total patient days Level 6 in 1977 | 816 ☐ ☐ ☐ ☐ ☐ ☐ |
| c. Total operating cost inpatient services 1977 | 822 \$ ☐ ☐ ☐ ☐ ☐ ☐ ☐ ☐ |
| d. Average cost per patient day 1977 (nearest \$) | 830 \$ ☐ ☐ ☐ ☐ |
| e. Average length of stay 1977 (nearest day) | 833 ☐ ☐ |
| f. Total senior citizen patient days 1977 | 835 ☐ ☐ ☐ ☐ ☐ ☐ |
| g. Total cost senior citizen care 1977 | 840 \$ ☐ ☐ ☐ ☐ ☐ ☐ ☐ ☐ |
| h. Avg. cost per senior citizen patient day 1977 | 848 \$ ☐ ☐ ☐ ☐ |
| i. Average senior citizen length of stay 1977 | 851 ☐ ☐ |

22. **STAFF COMPLEMENT: ESTIMATES TO NEAREST TENTH, e.g. 6.4, 0.8**

List no. of full-time equivalent (1 position = 1800 hours/year) personnel retained by your institution/branch/office, by category. **Include** positions CONTRACTED FROM other agencies; **do not include** positions CONTRACTED TO other agencies. List both total staff used for all services, and those used for services to **senior citizens only**; the latter figures should match the TOTAL POSITIONS column on chart question 17.

Personnel Category	Total Positions All Services	Positions for Sr. Cit. Services
a. Chief Executive Officer — PAID	853 ☐ ☐ ☐ ☐	856 ☐ ☐ ☐ ☐
b. Office/Clerical/Receptionist	859 ☐ ☐ ☐ ☐	862 ☐ ☐ ☐ ☐
c. Administrators (other than Chief Exec. Officer)	865 ☐ ☐ ☐ ☐	868 ☐ ☐ ☐ ☐
d. Reg. Nurse with degree (B.S.N.)	871 ☐ ☐ ☐ ☐	874 ☐ ☐ ☐ ☐
e. Reg. Nurse diploma only (R.N.)	877 ☐ ☐ ☐ ☐	880 ☐ ☐ ☐ ☐
f. Certified Nursing Assistants/Orderlies	883 ☐ ☐ ☐ ☐	886 ☐ ☐ ☐ ☐

g. Other Health Aides with some training	889	☐ ☐ ☐	892	☐ ☐ ☐
h. Homemakers	895	☐ ☐ ☐	898	☐ ☐ ☐
i. Handymen/Carpenters/Repairmen	901	☐ ☐ ☐	904	☐ ☐ ☐
j. Physiotherapists	907	☐ ☐ ☐	910	☐ ☐ ☐
k. Occupational Therapists	913	☐ ☐ ☐	916	☐ ☐ ☐
l. Speech Therapists	919	☐ ☐ ☐	922	☐ ☐ ☐
m. Social Workers	925	☐ ☐ ☐	928	☐ ☐ ☐
n. Psychologists	931	☐ ☐ ☐	934	☐ ☐ ☐
o. Physicians	937	☐ ☐ ☐	940	☐ ☐ ☐
p. Transit Workers — PAID	943	☐ ☐ ☐	946	☐ ☐ ☐
q. Other PAID _____	949	☐ ☐ ☐	952	☐ ☐ ☐
r. Other PAID _____	955	☐ ☐ ☐	958	☐ ☐ ☐
s. Volunteer Chief Exec. Officer	961	☐ ☐ ☐	964	☐ ☐ ☐
t. Volunteer Visitor, Transit, etc.	967	☐ ☐ ☐	970	☐ ☐ ☐
u. Volunteer other _____	973	☐ ☐ ☐	976	☐ ☐ ☐

23. ADDITIONAL INFORMATION AND COMMENTS

Please use this section to convey any information about your programs and concerns that you have not been able to provide elsewhere in the questionnaire. It is emphasized that all views on planning a program to coordinate services to senior citizens are most welcome, and the Task Force will be meeting with various organizations so that as wide a range of opinions can be heard. IF YOU WISH TO SUBMIT AN ADDITIONAL DETAILED WRITTEN BRIEF, PLEASE DO SO. HOWEVER, PLEASE SEND IN THE COMPLETED QUESTIONNAIRE AS SOON AS POSSIBLE SO THAT DATA PROCESSING CAN BEGIN.

Questionnaire

completed by: _____

Name

Position

Tel. No. _____

**APPENDIX 2B. INSTRUCTION MANUAL
FOR THE SENIOR
CITIZENS' SERVICES
INVENTORY
QUESTIONNAIRE**

APPENDIX 2B. INSTRUCTION MANUAL FOR INVENTORY QUESTIONNAIRE

NOTE: NUMBERS TO LEFT OF BOXES ARE FOR COMPUTER PURPOSES ONLY — PLEASE IGNORE

INSTRUCTION MANUAL FOR THE SENIOR CITIZENS' SERVICES INVENTORY QUESTIONNAIRE

This instruction manual is designed to explain any ambiguities related to

- a. wording of questions
- b. which programs are to be entered on the same questionnaire
- c. the specific kind of information asked by various sections
- d. definition of certain terms found in the questionnaire
- e. whether or not certain sections are applicable to your program(s)
- f. what to do if exact information is unavailable
- g. whom to contact for further clarification of the questionnaire.

It is highly unlikely that the questionnaire can be completed accurately without consulting the manual prior to responding to most questions. You are urged to consider the manual as an integral part of the questionnaire, and to have it available whenever you are in doubt as to what response is requested.

The following general guidelines should be adhered to in completing the questionnaire. Please note that in order to speed up the lengthy task of data processing, the questionnaire has been made largely computer-compatible. It has been designed so that respondents **can code the questionnaires themselves** by following the coding instructions indicated alongside the questions. Unfortunately, some errors in coding are unavoidable; as well, some changes in coding may have to be made after the questionnaires have been returned. The Task Force research staff will be checking each questionnaire to see that the coding is done appropriately. To help in this accuracy check, you are asked to comply with the following procedures:

1. Where the question is a multiple-choice type, circle the correct response as well as entering the appropriate code number in the space(s) provided. For example, if yours is a government organization, you would respond to Question #2 by a) circling 1 Government, and b) entering the digit "1" in the box to the right.
2. PLEASE COMPLETE THE QUESTIONNAIRE **IN PENCIL** AS LEGIBLY AS POSSIBLE.
3. The questionnaire will not be a complete success unless we get as complete a response to all questions as possible. Wherever ap-

appropriate, **ESTIMATE** an answer to a question if you do not have the precise data on hand, but have a reasonably accurate idea of what the answer might be. However, do not simply guess at a response; if you really have no idea of how to respond to certain questions — and particularly those where highly refined information is requested — it is permissible to leave the entry blank.

4. If certain sections do not apply to your organization, or if you are unable to answer certain questions, **PLEASE LEAVE THE APPROPRIATE COMPUTER BOXES BLANK. DO NOT CROSS THEM OUT, DRAW LINES THROUGH THEM, OR ALTER THEM IN ANY OTHER WAY**, as this hinders keypunching.
5. Please remember that careful planning cannot be done without detailed and comprehensive information. Our success depends largely on your response.

I. GENERAL GUIDELINES ON WHICH PROGRAM SHOULD BE ENTERED ON QUESTIONNAIRES

A number of organizations operate

- a. more than one distinct service program
- b. more than one residential facility with varying levels of care and programs
- c. a broad range of services with distinct client groups and purposes
- d. both inpatient and outpatient services for which separate records are kept
- e. a residential facility as well as a separate community service program

Because of this, some organizations may be unclear as to which programs and services should be combined and entered on the same questionnaire, or which should be entered on separate questionnaires.

It is intended that organizations be able to use their own judgment in determining whether or not programs should be combined onto one questionnaire, or whether separate facilities, programs, etc. should be entered on separate questionnaires. No doubt your decision will depend on such things as:

- a. type of record keeping system
- b. uniformity or diversity of programs in separate facilities
- c. whether or not administration is centralized or decentralized and so on.

The following guidelines may help you in making these decisions. If your situation is not covered by any of the options listed below, please phone the research staff at City Hospital for clarification.

1. Whatever decision you make, please **ensure that programs are not counted twice** — that is, programs and/or services should be entered on one questionnaire only. If there is any possibility that you and another agency/organization might include the same program on your

questionnaire, please arrange with that agency so that only one of you has included that program. You may want to include an explanatory note on what has been decided in this regard.

2. Acute Care Hospitals:

- a. Rural areas: hospitals outside Saskatoon may also house a number of community programs, e.g. meals-on-wheels. Please do not include such programs in the statistics on inpatient services. You may include such programs on the same questionnaire in the appropriate places; however please check with related community agencies to ensure that they are not counting the same program in their figures. Alternatively, you may wish to complete a separate questionnaire on which to enter all outpatient services.
- b. Saskatoon: city hospitals have a number of distinct programs, e.g. social work departments, physiotherapy and occupational therapy departments offering outpatient services, home care, etc. A number of alternatives are acceptable, although we prefer that home care programs be treated separately on an individual questionnaire. For the various hospital departments, you may either i) complete a separate form for those you consider to offer distinct programs or ii) combine the departments and include them in a single questionnaire for the entire hospital. Please be sure that you distinguish inpatient from outpatient services carefully, if at all feasible, and avoid double counting. We would appreciate receiving a note indicating what arrangements you have made.

- 3. Level 1-4 Institutions:** some organizations operate more than one distinct physical facility, e.g. three homes delivering Levels 1-3 care. A number of options are available. You may combine all of your facilities onto one questionnaire, or you may complete a separate questionnaire for each facility. Please indicate what you have decided upon.

As well, some organizations may operate both special care facilities and independent or "sheltered" housing units involving less than Level 1 care. We would prefer you to complete a separate questionnaire for the non-special care residences, as we are very interested in learning more about these facilities.

Some organizations operate significant day care/day center programs for community residents. If such programs are extensive, we would prefer them to be treated on a separate questionnaire (and to be deleted on the institutional questionnaire(s)). If it is impossible to separate out the community care programs, you may include them with the others on the same questionnaire.

If your organization operates both a residential/special care facility and other types of service programs, use at least two questionnaires if at all possible to reflect the separate nature of the programs.

- 4. Rural community services:** we have been given the names of people to contact in rural centres for information on community-based ser-

vices. If you wish to include all homemaker, meals-on-wheels, handyman, etc. services in your community on one questionnaire, feel free to do so. Please check with hospitals to avoid double counting of the same service. Please let us know if we have missed any rural service organizations on our list.

5. Please note that many of the questions ask you to indicate the services provided to **senior citizens** (65+). That is, we want to find out the range and volume of services **to the elderly** now existing. Even if you do not keep detailed, ongoing records of services provided to senior citizens as distinct from the general population, please estimate the proportions involved in care of the elderly. This is absolutely essential if we are to accurately assess the service situation.

II. EXPLANATIONS OF INDIVIDUAL QUESTIONS

2. Type of agency: this refers to the kind of organization you are and the role you play in the community.
 - a. Government: agency is operated and funded by the federal, provincial, or local/municipal government and reports directly to the appropriate level of government.
 - b. Private: agency is run as a business and is not responsible to any outside organization.
 - c. Voluntary: agency is operated as a community service, probably on a non-profit basis; there may be significant government funding, but the agency does not report directly to government. It may be required to conform to certain government standards and regulations.
3. Type of service to senior citizens: the distinction implied is that services are either institutional or community-based **depending on where the client receiving them lives**. The same service can be either institutional or community-based; for example, social work counselling can be either an institutional service to people in acute care hospitals, or a community-based service to people living in their own homes.
4. Area served: this applies to your own institution/branch/office **ONLY**. The purpose of the question is to determine the reach of various organizations' services.

In determining the area served, include clients who travel to the center where your agency is located to receive services. If, for example, clients from as far away as Hanley come to Saskatoon to receive your services, the correct response would be 3 Saskatoon & 30-plus mile radius.

For special care homes, etc., determine your service area according to where residents previously lived before coming to your facility. For our purposes, indicate the service area which defines the previous place of

residence of a significant — that is, more than just one or two — group of clients. If, for example, you operate a fifty bed special care home where forty-eight of the residents previously lived within 30 miles of your center and the other two came from centers forty and two hundred miles away, you would respond as if the drawing area was up to 30 miles.

5. ANNUAL BUDGET

- a. Total annual budget to nearest dollar: includes all expenditures by your organization for personnel, capital expansion/replacement, supplies & materials, etc., including funds for services contracted to other agencies for which you are reimbursed.
 - b. Budget excluding services contracted to other agencies: this figure should be the total amount you spend on services and other items you **actually deliver**. That is, include services contracted FROM other agencies for delivery under your direction, but exclude items contracted TO other agencies for use in other programs. The only purpose in asking for this breakdown is to avoid two agencies counting the same expenditure items, or double counting. This way, we can obtain the **net** total amount spent among all organizations surveyed.
 - c. Budget for institutional and community-based services: again, the categorization refers to where the client receiving the services lives. As in Question (3), institutional applies to residents of Levels 1-6 facilities, while community-based applies to residents of homes, apartments, etc. **The total for the two components should equal the response to Question (5b).**
7. Budget for senior citizens' services including contracted services from other agencies: again, this is the same type of response as indicated by Question (5b); however, indicate expenditures **on senior citizens ONLY**. Please estimate the amount if not precisely calculated.
- a. Value of services **CONTRACTED FROM** other agencies: that is, the value of services you obtain from another organization — you do not hire the staff and/or purchase the materials directly.
 - b. Value of services **CONTRACTED TO** other agencies: those personnel and services, etc. that you make available on a contract basis to other organizations for disposal as they see fit.
8. a. the breakdown of services **to senior citizens** into institutional and community-based components, again defined by place of residence of client.
- b. Value of services to Saskatoon and rural area residents: the purpose of this question is to discover how services **to senior citizens** are distributed among residents of the city, and residents elsewhere in the region defined by Saskatoon Rural Health. For Level 1-4 institutions, residents should be defined as city or rural depending on previous place of residence prior to coming to your institution. Estimate where possible.

9. ORGANIZATIONAL STRUCTURES AND AUTHORITY

This section is designed to locate the **formal** and **actual** sources of authority and decision-making in your organization. The following criteria apply:

- a. "Board of Directors" includes groups/bodies serving in this capacity even if they use a different name. For example, assume that a Provincial Advisory Committee or Provincial Executive Committee, etc. is the same as a Provincial Board of Directors for the purposes of response to this section. Likewise, the head of a local agency should be considered as the "Local Executive Director" even though he/she may use a different title.
- b. Any structure/person **required** to give written or verbal approval of a decision, procedure, etc. has **formal** responsibility over the matter in question. For instance, if the National Board of Directors is required by organization by-laws, regulations, long-standing tradition, etc. to approve the local budget, it is formally responsible for this area, regardless of the actual substantive role it plays in determining that budget.
- c. Any structure/person whose decisions and/or recommendations on certain matters are invariably, or almost invariably followed, regardless of the need for formal approval at another level, is considered **actually** responsible for those matters. For example, let us say that all referrals to other agencies must be channelled through the Local Executive Director. However, the recommendations of the field staff are almost never overruled. In this case, the staff is actually responsible for referrals. Similarly, the Local Executive Director is **actually** responsible for hiring/firing staff if his/her recommendations are routinely ratified by (say) the Local Board of Directors.

10. PROGRAM DETAILS: 65 AND OVER CLIENTS ONLY

- c. Average weeks on caseload: this figure can be longer than 52 weeks — the question is not restricted, as are the others, to a one year period.
- f.-s: Please indicate the MAJOR purposes of your service programs to the elderly. This should be interpreted according to criteria such as proportion of resources devoted to various activities; type of personnel available; and perceived desirable effects of programs. Although it is possible that an agency's programs will have a positive effect in almost all of these areas, please restrict your "Yes" responses to those areas where you feel you play a truly fundamental role.
- i. Although all services to the elderly may relieve some of the burden of care which falls among cohabitants, indicate "Yes" to this question only if it is a stated purpose of your agency to make it possible for cohabitants to continue to look after senior citizens without having to lead a significantly restricted lifestyle dictated by the level of care that person requires.
- r. This is for organizations which act in a lobbying, pressure group, or general advocacy role on behalf of senior citizens as part of their stated policies. Services may or may not be directly provided.

11. RESULTS OF PROGRAMS

This section asks information on what happens to clients on your caseload.

- a.- k. These questions are not mutually exclusive — that is, more than one outcome can apply to the same client, meaning that the total may add up to more than 100%.
- l.-t. These questions on reasons for discharging clients from the caseload **are intended to be mutually exclusive** — that is, we are seeking the MAJOR or SINGLE MOST IMPORTANT reason for clients leaving the program. Thus the total of l. through t. should approximate 100%.

12. CLIENT ASSESSMENT DETAILS

This section seeks information on WHO does the assessment; HOW MANY assessed **elderly** are eventually provided with services; STANDARD METHOD(S) of assessment; and WHAT FACTORS affect client eligibility.

The first chart on the top of page 12 asks information on who (which personnel category) does how many assessments annually, and how many of these are accepted onto the caseload. If the detailed breakdown by personnel category cannot be estimated, please indicate the total assessed and total accepted in the appropriate spaces.

NOTE: ASSESSMENT means that a client has been examined in some way, BY A HEALTH/SOCIAL SERVICE PROFESSIONAL AND/OR A REPRESENTATIVE OF AN AGENCY, with a view to determining the client's service needs. THIS DOES NOT INCLUDE SIMPLE FAMILY, SELF, etc. REFERRALS OR REQUESTS FOR SERVICES.

- d. Percentage undergoing various assessment procedures: total can add to more than 100% if more than one procedure can be undergone by a single client.

Client completes questionnaire means that the prospective client fills in a standard questionnaire independently — that is, without an agency representative and/or other professional being present for the purpose of ensuring accuracy of reporting.

Interviewer completes questionnaire means that an agency representative or other worker solicits the required information from a client and completes a standard form, thereby receiving and interpreting the data as necessary.

- e.- m.: Note that a YES response is to be indicated ONLY when the criterion in question is MANDATORY. For example, if your agency MAY accept clients referred by physicians, BUT PHYSICIAN REFERRAL IS NOT REQUIRED, part (f) should be answered 2 No. The same reasoning applies to the other sections.

- n.- u.: These questions are designed to show why assessed clients do not ultimately receive your organization's services. There can be more than one reason per client; however, please indicate only the percentages for whom each reason is **significantly** important.
- q. Indicate here the percentage of clients who need the **kind** of service you provide, but who need them in such quantity that you are unable to allocate such intensive resources to them either as a matter of policy, or to avoid adversely affecting your program as a whole. For example, if you provide a maximum of 12 hours of homemaking per week and a client needs 36 hours a week, this is the appropriate section to indicate that you are unable to provide the intensity of services required IF YOU DO NOT DELIVER THE SERVICES BECAUSE OF THIS DISCREPANCY.

13. EXISTING COMMUNICATIONS

- c. Referral patterns: this section seeks information on what types of referrals are made in the system, and the organizations/individuals from whom and to whom your agency receives and makes referrals.

The different categories of referral agents are intended not to overlap. DO NOT count the same referral under more than one category unless there have been two distinct referrals for the same case.

Indicate the totals even if you are unable to break down your referrals into the categories in the table.

17. STAFF AND ACTIVITIES: DEFINITIONS

Administration: all activities involved in operating an organization, such as planning, staffing, supervision, budgeting, record-keeping, typing, statistical reviews, correspondence, filing, etc. It also includes coordination of services and assignment of duties to personnel. Office/clerical staff would perform much of the administration; however, most, if not all other personnel are involved to some extent in the activity.

Assessment: all activities related to gathering information and determining the client's service needs; determining who should provide the services; and determining the length of time of service duration. This includes both initial assessment, and continuing assessment or monitoring of the client that may lead to changes in service provision.

Direct nursing care: refers to the application and execution of nursing principles, techniques and procedures in promoting and maintaining health of clients. It largely involves **direct contact** with clients in periods of stress, illness, convalescence, etc. A wide range of activities is involved, among which are: taking/evaluating vital signs (e.g. blood pressure); giving medications and injections; wound care; catheter care; etc. These activities most likely require professional nursing training to some extent — though not necessarily the

Registered Nurse level for all activities — and may be carried out under supervision in some instances. Not all the activities of nurses will be direct nursing care; see other definitions which may also apply.

Personal care & hygiene: activities such as bathing, grooming, dressing, feeding, and any other comfort measures provided for a client. Personnel may or may not have formal training in carrying out these activities.

Homemaking: activities related to household maintenance (though not repair or modification), including shopping, meal preparation **in the home** — not Meals-On-Wheels — cleaning, laundry, etc.

Physiotherapy: the use of physical agents and methods in rehabilitation and restoration of normal bodily function after illness or surgery. This includes massage, manipulation, therapeutic exercises, hydrotherapy, and various forms of energy (e.g. electrotherapy). Some of these activities can be carried out by various personnel categories **under the direct supervision of a physiotherapist.**

Occupational therapy: usually refers to some type of work or occupation that is used in the convalescent period to promote recovery. It is geared toward helping a client recover functional capacities, and therefore includes any type of therapeutic activity encouraging self-expression and the use of resources that may aid the process of achieving normal abilities both in the workplace and with respect to activities of daily living. Some of these activities can be carried out by other personnel **under the direct supervision of the occupational therapist.**

Speech therapy: the use of special techniques for correction of speech and language disorders. Under the direct supervision of the speech therapist, other personnel may help the client with exercises, etc.

Counselling: the exchange of information between client and worker, with a view to discussing problems, planning programs to deal with difficulties, and giving advice. It can cover a wide range of areas such as financial, legal, resource accessibility, personal, family and health matters. **EXCLUDE COUNSELLING RELATED TO NUTRITION AS THIS IS INCLUDED IN ANOTHER CATEGORY.**

Casefinding: through work within the agency, in the community, and/or through contact with clients and families, the worker actively seeks out elderly people who may be at risk and in need of services.

Making referrals: written or verbal direction of a client to receive information and/or services from another agency, person, institution, etc.

Diet therapy & instruction: prescribing and interpreting therapeutic diets to clients, as well as providing information and education on special diets and nutrition.

Psychological testing & treatment: the use, by trained psychologists, of special tests and therapy methods such as behavior modification, personality assessment, etc. to help clients with potential or actual psychological problems. **INCLUDE PSYCHIATRIC SERVICES.**

Physician services: all activities performed by medical doctors, **EXCLUDING PSYCHIATRISTS** but including all other specialties; particularly in the area of medical diagnosis and treatment.

Transportation: the transporting of clients for shopping, appointments (e.g. doctor appointments), social activities, church, etc. Also includes delivery of groceries, meals-on-wheels, etc.

Home repairs/modification: activities carried out to improve conditions in the home and/or structural maintenance of the home. Included are installation of equipment (e.g. grab rails); painting; putting on storm windows; repair work; etc. **DO NOT INCLUDE GENERAL CLEANING.**

Friendly visiting & surveillance: contact with clients to provide social interaction and/or routine checking in on the elderly. This includes visits and phone contacts.

20. **SHELTERED HOUSING PROJECTS**

This section should be completed **ONLY** by organizations operating facilities to house the elderly (and perhaps some others) in independent or semi-dependent units **WITHOUT PROVIDING SERVICES TO THE EXTENT OF LEVEL 1 CARE.** That is, these are primarily residential facilities such as senior citizens' highrises; cottage-type units, perhaps adjacent to a special care home; a senior citizens' housing project in a town or village; a residence where clients congregate centrally for meals and perhaps other activities, with neither separate kitchens in each unit nor any special care provided; etc.

21. **ACUTE CARE HOSPITALS: SEE ALSO PAGE 2 OF MANUAL**

Please ensure that **inpatient service ONLY** is included in this section in order to avoid double counting of programs and/or department activities. If it is not possible for you to distinguish between inpatient and other services, at least let us know where you have combined programs of both an inpatient and community service nature, as defined elsewhere.

- g. and h.: estimate if possible the expenditures for senior citizens' inpatient care and average cost per patient day so that we can ascertain whether or not there are significant differences in intensity of care, type of care, etc. occurring in this age group (for whatever reason), compared to the general population.

**APPENDIX 2C. MAILING LIST
FOR SERVICE
INVENTORY
QUESTIONNAIRE**

APPENDIX 2C

MAILING LIST FOR SERVICE INVENTORY QUESTIONNAIRE

A. RESPONDED TO QUESTIONNAIRE

Saskatoon Convalescent Home
Central Haven Personal Care Home
Sunnyside Nursing Home
Elmwood Residences
Jubilee Residences Ltd.:
 Porteous Lodge
 Stensrud Lodge
Sherbrooke Community Centre
Frank Eliason Centre
Salvation Army Eventide Home
 and Hospital
St. Joseph's Home
Extendicare Ltd.
Warman Mennonite Alten Heim
City Hospital
University Hospital
St. Paul's Hospital
Borden Union Hospital
Evergreen Neighbourly Services
Friendship Inn
Alliance of Youth and the Elderly
Victorian Order of Nurses
Sherbrooke Day Centre
Community Aid/Resource Centre
Ostomy Association
Community Clinic
 Social Services (Elderly)
 Nutrition Dept.
 Physiotherapy Dept.
 Occ. Therapy Dept.
 West Side
Saskatoon Home Care Program
Saskatoon Health Dept.
Co-Op Assoc. Grocery Delivery
Psychiatric Home Care
Saskatoon Mental Health Clinic
Catholic Family Services
Family Service Bureau
Warman Senior Service
Saskatoon Rural Health Region

Delisle Community Health
 and Social Centre
 Langham Community Services
 Radisson and District
 Community Services
 Central Haven Senior Citizens Home
 Jubilee Residences Ltd.
 Mt. Pleasant Court
 Mt. Royal Court
 Cosmopolitan Courts
 Eamer Court
 Fairview Court — Jubilee
 Housing Corp.
 Sask. Hearing Aid Plan
 Dept. of Social Services —
 Saskatoon Region
 Sask. Council for Crippled
 Children and Adults
 Dept. of Veterans' Affairs
 Sask. Aids to Independent Living

B. DID NOT RESPOND TO QUESTIONNAIRE

Del Haven Lodge*
 Eastern Star Court*
 Lutheran Sunset Home & Tower*
 Oliver Lodge*
 St. Ann's Home*
 Saskatoon Sanitorium
 (Level 4 Ward)*
 Veterans' Home*
 Cancer Clinic*
 Legal Assistance Clinic
 Self-Help Council
 Canadian National Institute
 for the Blind*
 McKerracher Centre*
 Langham Holiday Home*
 Dalmeny Home for the Aged*
 Convent of Sion
 Saskatoon Local Housing
 Authority*
 Sask. Assoc. for the
 Mentally Retarded
 Mental Health Association
 Canadian Paraplegic Association
 Canadian Cancer Society
 Core Services
 Diabetic Education Centre
 37 Private Special Care Homes

* significant omission from survey

**APPENDIX 2D. HEALTH AND
SOCIAL SERVICE
INVENTORY**

APPENDIX 2D

HEALTH AND SOCIAL SERVICE INVENTORY

The Terms of Reference required the Task Force to take an inventory of existing services in the project area. As has been the case elsewhere, this seemingly straightforward task proved to be very complex, and it is unfortunately necessary to report that we did not completely succeed in discharging it.

However, we did manage to collect a substantial body of useful information through two procedures: first, a canvassing of provincial and other sources, notably our Panel of Experts and the Senior Citizens' Provincial Council, who had assembled some of the necessary data; and second, the distribution of a detailed questionnaire to a large number of organizations, with emphasis on those presumed to be engaged in delivering services to senior citizens.

It soon became apparent that there is a wide range of sophistication in record keeping systems throughout the service area. Some agencies, mainly special care homes, maintain detailed records, a task made relatively easier by the nature of institutions and their clientele. Some organizations, mainly community agencies, do not have the resources to compile refined statistics on their activities, with the result that in many cases it proved impossible to differentiate services delivered to the general population from those delivered to the elderly; to males as distinct from females; and to city residents as distinct from rural residents.

In addition, there is a lack of information on the impact of service delivery on client health, environmental circumstance, and so on. While there is a lot of raw information on how many people receive what services, there has traditionally been little attempt to measure the effects of interventions by agencies and institutions. Thus it would be extremely difficult even to estimate the relative net return of each dollar spent in one area compared to another.

Appendix 2C shows the mailing list from the questionnaire survey, and the list of respondents. Non-respondents marked with an asterisk are considered to be quite important organizations whose absence rather seriously affects the comprehensiveness and accuracy of the overall data. We have tried to estimate certain figures, particularly financial, for major non-respondents where possible in order to make the inventory as complete as possible.

These caveats make it necessary to interpret the data with some caution, particularly where budgets, caseloads, and similar statistics are involved. This being the case, we are in the main satisfied that we have been able to

account for the vast majority of services offered in the service area, of which roughly one-third are devoted to the elderly. While the total figures may be out by as much as ten million dollars — a not insubstantial amount — the general order of magnitude is correct, and it is safe to say that from ninety to a hundred million dollars annually are spent on health and social services in Saskatoon and surrounding municipalities. That is not say, however, that expenditures apply only to area residents; on the contrary, many residents of central and northern Saskatchewan look to Saskatoon for a number of services, and particularly sophisticated hospital facilities.

The survey also solicited opinions on both the performance of the current system relative to a number of functions, and the likelihood of participation in a number of measures aimed at rationalizing service delivery. The responses to these sections proved most interesting, and the results are in our view indicative of a need to implement certain elements of program design.

The remainder of this section will present the results of both general information gathering and responses to the questionnaire. It is to be hoped that in the future, all participants in the health and social service delivery system will develop a common approach to data collection and analysis which will make it possible to take a truly comprehensive inventory as a matter of course. If this were achieved, it would no doubt be a first in Canada, and would greatly facilitate the monitoring and evaluation of huge expenditures from the public treasury. As matters currently stand, organizations are accountable for expenditures only in the most basic sense. This does not mean that funds are being misused or that programs are unsatisfactory; it does mean, however, that it is impossible to make definitive assessments of program performance, and it is likewise impossible to justify at least some expenditures in times when budget constraint pressures are particularly strong. If the health field is to fend off charges that it is occupying too prominent a place in Government budgets, its components will have to demonstrate both individually and collectively that the public is getting precisely defined benefits for well-monitored dollars.

I. GENERAL SURVEY CHARACTERISTICS

The questionnaire was distributed to approximately 120 agencies in Saskatoon and Rural Health Region #8. This included 37 private special care homes in the city; 24 larger special care homes; 2 institutions providing Level 4 (extended) care; 6 acute care hospitals; 43 community agencies ranging from small meals-on-wheels or homemaker programs in rural centers to large, province-wide organizations such as the Saskatchewan Council for Crippled Children and Adults and the Saskatchewan Hearing Aid Plan; and, 4 housing authorities and projects.

After the survey was begun, the Task Force decided to limit the project boundaries to the municipalities comprising the home care district surrounding the city. As a result, several questionnaires which were returned from the Rural Health Region have not been included for analysis.

We are grateful nonetheless for the willing participation of respondents from outside the project area, and we trust that completing the questionnaire provided organizations with a useful opportunity to examine their data.

Forty-seven questionnaires from the project area were returned, including 40 from Saskatoon and 7 from the rural area adjacent. After a perusal of various community directories and contact with a number of people familiar with service organizations, it was concluded that there were 69 potential responses from agencies involved to any significant extent in provision of services to the elderly. This figure excludes the 37 private special care homes from which no responses were received. In addition to the 47 who responded, 8 informed the Task Force that they would not be returning a completed questionnaire because of lack of time, unavailability of information, or inapplicability of the survey to that organization. Thus the total response rate was 47/69 or 68.1%; excluding the 8 mentioned above, the rate was 47/61 or 72.0%. However, 13 of the non-respondents can be considered significant omissions from the survey, while perhaps 10 of those who did respond represent agencies only marginally involved in provision of service to senior citizens, either because of agency orientation or small budget. Thus of important agencies and institutions serving the elderly, the response rate was roughly 37/51 or 72.5%, which given the length of the questionnaire and the normal aversion to surveys is quite good.

Twenty-eight respondents — 59.6% of the sample — described themselves as voluntary agencies, with 25.5% (12) being government agencies, 8.5% (4) private, and 6.4% (3) other. Sixty-one point seven per cent (29) offer community based services, 31.9% (15) provide institutional services, and 6.4% (3) provide both. Only 19.1% (9) provide service limited to the city boundaries, while one other agency covers only one part of Saskatoon (2.1%). Twenty-seven organizations (57.4%) provide service to residents who live outside the roughly 30 miles radius extending outward from Saskatoon which describes the home care district, including all of the city institutions which responded. This suggests that while a great deal of money is spent in Saskatoon on health and social services, it is erroneous to assume that all of the funds are spent on city and District residents, particularly at large referral institutions such as University Hospital.

The respondents reported total expenditures of \$95 million on all age groups, which includes \$20 million spent by the Department of Social Services (mainly on income support programs), and excludes roughly \$20 million paid to physicians and other professionals through M.C.I.C.; \$5 million spent on special and extended care beds in institutions which did not respond to the survey; up to \$1 million provided to residents of private special care homes; and an estimated \$2 - \$5 million spent elsewhere by non-respondents.

According to the responses, funds come almost exclusively from 3 sources: 89.5% from the provincial government; 9.8% from client charges; and .6% from local government. This is not surprising when one

considers that fully insured hospital and Level 4 care figures are included along with Social Services payments to eligible beneficiaries.

Not all agencies were able to break expenditures down into general and senior citizen figures. Of the 39 who did (including all of the organizations with budgets over \$1 million annually), some \$31.4 million was reported spent on the elderly. Estimating totals for non-respondents leads to the conclusion that about 35% of all health and social service expenditures go to senior citizens.

As many analysts have surmised, the figures are heavily weighted toward the institutional sector. About two-thirds of the respondents were able to distinguish institutional from community-based expenditures. Of the \$71.5 million accounted for, \$66.4 million falls in the institutional classification, while only \$5.1 million — 7% of the total — goes for community-based services. (The figures exclude income supplements from Social Services.) The ratio is only slightly different from senior citizen expenditures, where 11% of the \$26.1 million broken down is spent on community based services.

Thirty-eight agencies reported a current elderly caseload of 8,218, while 41 organizations reported 22,016 elderly cases served annually. Obviously, a large proportion of cases are double counted by two or more agencies. Somewhat more females than males are served, and services for women are significantly more expensive: 5 out of every 8 dollars (62.5%) are spent on elderly women compared to 37.5% on elderly men.

Table 2D.1 Indicates the major purposes of respondents' programs.

Table 2D.1 — Major Purposes of Programs as Reported by Survey Respondents (65+ Clients Only).

Purpose	Yes		No	
	No.	%	No.	%
Maintain client in independent residence	29	64.4	15	35.6
Stabilize or improve medical/physical condition	32	72.7	12	27.3
Stabilize or improve emotional/mental condition	33	76.7	10	23.3
Relieve cohabitants of some of burden of care	24	55.8	19	44.2
Improve client ability to perform activities of daily living	36	80.0	9	20.0
Provide recreation/entertainment/stimulation program	24	53.3	21	46.7
Provide required care in institutional setting . .	14	34.1	27	65.9
Shorten acute care hospital stay	14	31.8	30	68.2
Shorten Levels 1-4 special care/nursing home stay	14	31.8	30	68.2
Improve client's material/financial circumstances	7	16.3	36	83.7
Structurally improve client's physical environment	9	20.5	35	79.5
Provide education/referral advice to client . . .	27	61.4	17	38.6
Play advocacy role for elderly in general	18	40.9	26	59.1
Other	8			

Most organizations consider their role to be to stabilize or improve physical or psychological conditions and to improve the ability to carry out the activities of daily living. These perceptions imply a strong rehabilitation component. Furthermore, 14 organizations perceive that at least one purpose is to shorten acute care hospital stays, while a similar number believe their programs shorten Levels 1-4 institutional stays. If this is the case, there are obviously many community agencies which consider themselves able to participate in both post-acute and chronic home care programs.

Respondents also indicated the results of their programs; in some instances these statistics can be compared to those in Table 2D.1 above as a partial measure of how successful programs have been in carrying out their stated purposes.

Table 2D.2 — Results of Program Activities as Reported by Survey Respondents, for Clients Served (65+ only).

Result	No.	Client Participation Range *
Medical/physical condition improved/stabilized	27	40-49%
Emotional/mental condition improved/stabilized	28	40-49
Client improves until services no longer required	27	15-24
Client stabilizes with need for stable level of services	26	37-46
Client deteriorates with increased need for services	26	13-22
Admission to acute care hospital prevented/delayed	25	26-35
Admission to Level 1-4 institution prevented/delayed	23	25-34
Early discharge from acute care hospital made possible	20	20-29
Early discharge from 1-4 institution made possible	20	2-11
Client referred to appropriate service organization	28	16-25
Other	11	20-29

* Respondents were asked to indicate the proportion of clients served to whom each result applied, using ten percent ranges, e.g. 30-39%, 80-89%. The figures presented are the mean range responses of each category.

If the figures are accurate, it would appear that about 1 in 5 clients of all organizations (including acute care hospitals) improves to the point that full independence is regained, while a similar proportion deteriorates with an increased service need. It is interesting to note that from one-quarter to one-third of all clients benefit from the preventive aspects of programs to the extent that admission to Levels 1 to 6 institutions is either prevented or delayed according to roughly half the respondents, while 20 organizations believe their services make it possible for a quarter of their clients to return home from hospital earlier. The latter figure is noteworthy when it is considered that only 14 organizations listed shortening hospital stays as a major purpose.

There do not appear to be universally prevalent criteria according to which clients are eligible for admission to programs.

**Table 2D.3 — Criteria for Client Eligibility for
Admission to Programs (65+ Clients only).**

Criterion	Yes		No	
	No.	%	No.	%
Must have medical/physical/emotional condition	28	65.1	15	34.9
Must have referral from physician	19	44.2	24	55.8
Must have referral from another agency	2	4.7	41	95.3
Must have financial hardship	3	7.0	40	93.0
Must have ability to pay	4	9.3	39	90.7
Self referral — application for services sufficient	16	37.2	27	62.8
Client must require minimum no./level of services	14	32.6	29	67.4
Client must need no more than defined maximum no./level of service	9	21.4	33	78.6
Other	3			

Three of the results are particularly noteworthy. First, it is surprising that 15 respondents will serve clients who do not have any form of medical, physical, or emotional condition. Even reducing this number to account for the one or two funding agencies in the area, it still appears to be the case that one need not have a recognized disability to receive services. Second, fewer than half the respondents, and hardly any community agencies, reported that a physician referral was required for delivery of services. Third, 16 organizations reported that client application for service was sufficient indication of need to be considered eligible for service. Clearly, the assessment, screening, and priority setting process is not highly refined in a formal manner, a shortcoming which respondents identified (see below). In fact, only 45.2% (19) organizations reported that they use any kind of written assessment form, whereas 54.8% (23) indicated that they do not.

Because of some ambiguity in the questionnaire and incomplete data among respondents, the information of clients and caseloads is probably inaccurate and somewhat understated. As well, it was not possible to distinguish between discrete clients and number of cases in all instances, with the result that some clients have been counted a number of times, both within and across numerous agencies. The data are presented below mainly to indicate in a general way the volume of service currently delivered.

Thirty organizations reported assessing 25,000 elderly cases; it is clear that many senior citizens undergo multiple assessments, particularly in institutions where several staff might be involved. No doubt "assessment" has been interpreted rather broadly in many instances. Thirty-four organizations reported receiving 13,393 referrals from all sources. Senior citizens received the following services.

Table 2D.4— Services Delivered Annually to Senior Citizens.

Service	No. Cases Served	No. Agencies Delivering
Nursing	9,097	20
Homemaking	1,879	9
Meals on Wheels	374	9
Physiotherapy	5,629	12
Occupational Therapy	437	8
Speech Therapy	26	6
Psychiatric	72	6
Other M.D. Service	5,493	11
Transportation	866	11
Home Repairs, etc.	1,880	9
Friendly Visits	3,956	15
Recreation/Entertainment	5,426	15
Social Work	3,623	13
ALL SERVICES	38,758	36
		discrete agencies

Table 2D.5 — Total Staff in Existing System, and Proportion of Resources Devoted to Senior Citizens

Category	Staff Total	No. of Agencies	Senior Citizen Total	No. of Agencies
Chief Exec. Officers	31.0	31	15.3	26
Clerical	260.6	29	137.0	25
Administrative	38.0	17	15.7	16
Degree Nursing*	93.0	8	17.5	7
Reg. Nursing*	999.1	21	388.0	19
CNA/Orderlies	260.8	11	94.3	10
Other Health Aides**	538.9	20	287.2	17
Homemakers	56.8	7	17.1	7
Handymen, etc.***	87.3	16	44.7	16
Physical Therapists	43.3	9	14.5	9
Occupational Therapists	14.0	5	5.2	5
Speech Therapists	6.2	3	1.4	3
Social Workers†	138.7	14	21.0	14
Paid Transit Workers	22.3	3	5.4	3
Other Paid	182.8	24	170.7	22
TOTAL PAID	2,772.8	45	1,235.0	42
		discrete agencies		discrete agencies

NOTE: Staff figures unavailable for one small rural community program plus one city nursing home.

* Includes some degree nurses where organizations did not differentiate B.S.N.'s and R.N.'s

** Approximate only, with many definitions.

*** May include some part-time personnel.

† Includes 85 employees of Saskatoon Regional Office of Department of Social Services, 3.4 of whom work with elderly; includes non-degree personnel.

Respondents also reported 59.9 full-time equivalent volunteer visitors (in 14 agencies), 55.9 of whom deal with senior citizens, and six organizations have enlisted the equivalent of 23.3 other volunteer workers, 13.5 of whom work with the elderly.

There are vast quantities of human resources already in the system, many of whom serve Saskatchewan residents outside the proposed service district. A relatively small shift of personnel from the institutional to the community sector could result in a considerable expansion of the latter's programs.

II. ACUTE CARE HOSPITALS

The three Saskatoon Hospitals and the Borden Union Hospital spend \$46.6 million annually, about half the health and social service total for the area. Of this amount about a third — \$14.2 million — is spent on the care and treatment of senior citizens. Total bed count is 1,241 (rated capacity).

Saskatoon is a referral center for the northern part of the province, and in some instances for the entire province. As a result, it is estimated that of the \$14.1 million spent on the elderly in city hospitals, some \$9 million is used by residents who do not live in Saskatoon. The most dramatic illustration of this phenomenon occurs at University Hospital, where \$5.1 million is spent on senior citizens from outside the city while only \$1.3 million is spent on their Saskatoon counterparts.

III. SPECIAL AND EXTENDED CARE (LEVELS 1-4) HOMES

There are 19 institutions providing Levels 1 to 4 care in Saskatoon, and 3 homes (in Dalmeny, Warman, and Langham) providing Levels 1 and 2 care in the rural area. Included in the city facilities are Cheshire (9 beds) and Elmwood Residences (120 beds) for the mentally retarded who are for the most part under 65.

Eleven agencies representing 12 institutions (Jubilee Residences operates Porteous Lodge and Stensrud Lodge) participated in the survey, including Elmwood. These accounted for \$12 million in 1977, two thirds of which was spent on Level 3 care. Table 2D.6 portrays the special care and extended care system in the area, based on data received and estimates for facilities which did not respond to the survey.

Table 2D.6 — Senior Citizens' Levels 1 to 4 Beds and Expenditures in the District.

Level of Care	No. of Beds	Total Expenditures
1	225	\$ 1,080,000
2	420	2,875,000
3	800	8,785,000
4	130	2,340,000
TOTAL	1,575	\$15,080,000

An estimated \$15 million is spent on the elderly, including 100% of Levels 1 & 2 expenditures (excluding the young retarded), roughly 90% of Level 3 (excluding 75 young adult retarded at Sherbrooke), and 75% of Level 4. Approximately 1,575 senior citizens are institutionalized in the District — 89 outside the city — which is somewhat more than 10% of the total elderly population. However, as Saskatoon serves a larger area than the District under consideration, it is impossible to determine accurately the bed ratios per thousand senior citizens. It is interesting to note that 9 Saskatoon homes with budgets totalling \$9.6 million reported that \$3.0 million is spent on senior citizens who previously lived outside the city, and that 7 of these homes reported service areas of from 30 miles and up to the entire province. It is highly probable, then, that many residents come from outside the proposed District, and that the elderly population served by existing beds is in the neighbourhood of 20,000.

IV. COMMUNITY SERVICE AGENCIES

About two dozen community agencies in the city and 5 in the rural area responded to the survey. Of \$4.6 million spent by city agencies, roughly \$1.75 million is for the elderly; corresponding figures for the surrounding area are \$400,000 and \$90,000 respectively. No doubt some city agency expenditures flow to residents of the rural area as well, so the amounts should not be interpreted too rigidly.

Of the larger city agencies — those with annual budgets of \$100,000 and over — only groups involved in home care (the University Hospital program, Family Service Bureau, and the Victorian Order of Nurses), the Alliance of Youth and the Elderly, and the Saskatchewan Hearing Aid Plan regional office spend most of their funds on senior citizens. The same holds true in the surrounding area, where the two largest organizations (Rural Health Region #8 and the Delisle Community Health and Social Centre) spend the proportionally lowest amounts on the elderly. Taken cumulatively, however, roughly one-third of both institutional and community expenditures are devoted to the elderly.

V. PUBLIC HOUSING

There will soon be over 900 senior citizen housing units in Saskatoon and rural area, including 500 under the authority of the Saskatoon Housing

Authority. Unfortunately, the response to the survey from this sector was poor, with only 355 urban units accounted for. The survey results are not particularly helpful in ascertaining the subsidized housing situation in the area.

The public housing units in Saskatchewan are not comparable to sheltered housing in Europe. Rather, this province has concentrated on building housing for the well elderly whose needs for supervision and services are minimal. They are therefore primarily economic aids — rents are traditionally lower than in the public sector, although differences are shrinking as costs of new units become increasingly prohibitive — and have not proved to be alternatives for senior citizens with significant functional incapacities.

The trend in Saskatoon has been toward construction of highrise projects in locations with relatively easy access to shopping and other facilities. Some new buildings have provision for serving a daily hot meal to residents; in fact, in one project the meal is mandatory. The newest Saskatoon project has set aside 5 units for wheelchair residents, with suitable design features. Older projects range from adjuncts to nursing home campuses to cottage type units with individual yards.

VI. SUMMARY

Figures 2D.1 to 2D.3 show the location of housing and special care homes in Saskatoon, and services available to senior citizens in the rural area. Substantial amounts of money are spent in the District, and there are ample institutional beds. While on the surface it appears as if the rural communities are grossly underfunded, it must be borne in mind that these adjacent areas look to Saskatoon as a major service center, and rural residents without question are regular users of health and social services delivered in Saskatoon.

Problems do occur in rural areas where there are no centers sufficiently large to develop localized services. The southeastern part of the district has little choice but to look to Saskatoon for virtually all services. Whether or not services can be delivered locally will be a test of how feasible it proves to be to decentralize programs significantly without incurring unacceptably high costs per unit delivered.

VII. PERCEPTIONS OF SELF, SYSTEM AND RATIONALIZATION OF SERVICES

Respondents were asked to assess their own, and the system's performance in 17 areas, and to indicate the likelihood of their own, and the system's participation in 15 possible measures aimed at rationalizing service delivery. The results are presented below in Tables 2D.7 and 2D.8.

It is immediately apparent that individual organizations have a much higher

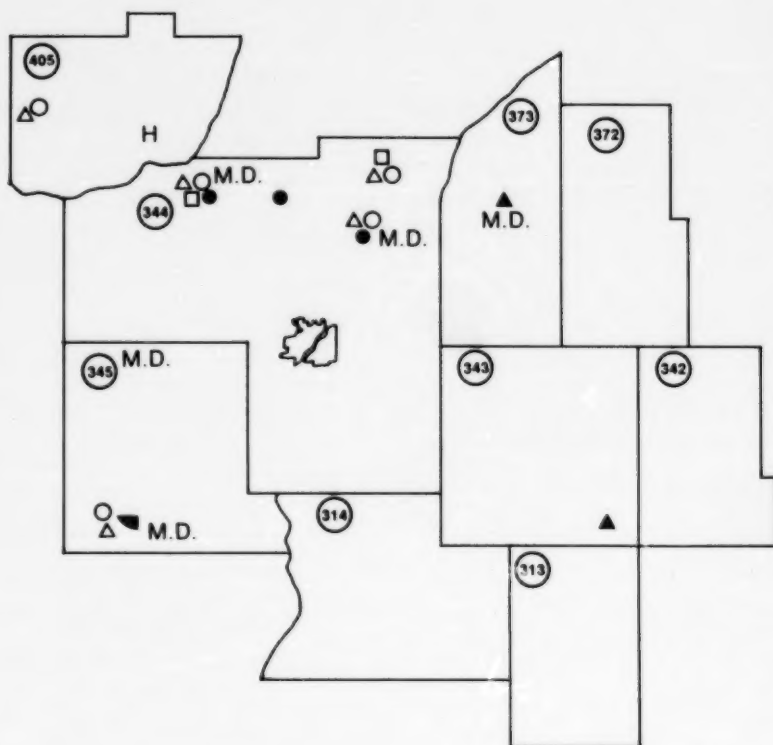
Figure 2D.1 — Location of Special and Extended Care Homes, Saskatoon.



Figure 2D.2 — Location of Senior Citizens Residences and Public Housing Units, Saskatoon.



Figure 2D.3 — Location of Services for Senior Citizens in Rural Areas.



- ▲ — senior citizens housing*
- △ — homemaking
- — meals-on-wheels
- ◻ — handyman
- — special care home
- ▲ — health and social centre
- M.D. — visiting physician
- H — hospital

*May be incomplete due to unavailability of Saskatchewan Housing Corporation data.

regard for their own performance than that of the system as a whole. While it was not uncommon for agencies to rate their own performance as excellent, the overall system received such accolades rarely — in fact, a tenth as often. In only one category — range of services offered — did even half of the respondents rate the system as excellent or good, while their own performance was rated good or better in 16 of the 17, the sole exception being program evaluation. Taking all responses together, self evaluation resulted in a good or excellent rating in 75.7% of cases where an opinion was expressed, while the system was rated fair or poor in 61.7% of similar cases.

It is difficult to conclude other than that organizations view themselves with considerable satisfaction, and their colleagues in the system with some reservation. Where appraisal of one's own performance consistently exceeds the perception of one's colleagues, it is reasonable to expect certain shortcomings in interagency referrals and other forms of communication vital to an efficient, coordinated delivery mechanism. It is striking that agencies who with virtual unanimity perceive themselves to be doing a good job are also relatively unimpressed with the system as a whole. The whole, then, is not equal to the sum of its parts — according to these very parts.

Table 2D.8 shows agencies' assessments of the likelihood of themselves, and the system as a whole participating in the 15 possible operations to improve service delivery. Again there is the phenomenon of agencies seeing themselves as willing to cooperate in rationalization, and the system as being less likely to participate. With the exception of coordinated staff hiring and amalgamation of identical service organizations, a majority of respondents indicated that the chances of participating in these measures were good or excellent as far as their own groups were concerned. However, in only one instance — coordinated geriatric education — was the system perceived as having excellent or good possibilities for success. Taking all responses together, and excluding the no response/not applicable categories, 74.0% of respondents indicated good or excellent probability of themselves participating in the measures, while half this ratio of favourable responses (37.6%) was indicated for the system overall. The fair and poor indications comprised only 26.0% of self appraisals regarding participation compared to 62.5% of the assessments of the system.

Respondents were asked to list up to 5 services most urgently needed to improve health and social services in the area. These could be either new or expanded services. Table 2D.9 shows the results of two ways: the first column records the number of times the service was mentioned, while the second recognizes as well the ranking in importance of the suggestions by assigning 5 points for each time a service was mentioned as the first priority; 4 points as second priority; etc.

By and large, the concerns of service agencies and senior citizens overlap, with some difference in emphasis. It is interesting to note that the agencies, having perceived themselves as both more proficient and more

likely to participate in coordination than their counterparts in the system as a whole, listed a central assessment, referral, and placement mechanism as the single most important need. This indicates a desire for some form of umbrella mechanism to ensure that clients are properly assessed and served. Otherwise, both agencies and senior citizens list basic home care services such as meals, nursing, and homemaking as paramount, with the elderly themselves expressing a need for transportation, community alarm systems, household modification, and friendly visits as also essential to the maintenance of independence.

Table 2D.7 — Individual Agencies' Assessments of Own and — System Performance of Functions.

Function	Own					System						
	Exc.	Good	Fair	Poor	No Opin.	Not Applic.	Exc.	Good	Fair	Poor	No Opin.	Not Applic.
Administrative Efficiency	13.9% (5)	72.2% (26)	8.3% (3)	2.8% (1)	—	2.8% (1)	—	41.2% (14)	41.2% (14)	11.8% (4)	2.9% (1)	2.9% (1)
Range of Services Offered	27.0 (10)	43.2 (16)	29.7 (11)	—	—	—	2.9 (1)	51.4 (18)	37.1 (13)	2.9 (1)	4.7 (2)	—
Volume of Service Delivered	10.8 (4)	51.4 (19)	32.4 (12)	5.4 (2)	—	—	2.9 (1)	29.4 (10)	44.1 (15)	14.7 (5)	8.8 (3)	—
Assessment Mechanisms	16.2 (6)	45.9 (17)	27.0 (10)	2.7 (1)	5.4 (2)	2.7 (1)	2.9 (1)	29.6 (7)	44.1 (15)	20.6 (7)	8.8 (3)	2.9 (1)
Referral Mechanisms	8.3 (3)	69.4 (25)	11.1 (4)	2.8 (1)	2.8 (1)	5.6 (2)	2.9 (1)	28.6 (10)	31.4 (11)	25.7 (9)	5.7 (2)	5.7 (2)
Internal Planning	—	66.7 (24)	22.2 (8)	2.8 (1)	2.8 (1)	5.6 (2)	—	29.4 (10)	29.4 (10)	14.7 (5)	20.6 (7)	5.9 (2)
Planning With Other Agencies	—	58.3 (21)	22.2 (8)	11.4 (4)	—	8.3 (3)	—	22.9 (8)	20.0 (7)	37.1 (13)	11.4 (4)	8.6 (3)
Recruitment of Staff	29.7 (11)	51.4 (19)	13.5 (5)	2.7 (1)	—	2.7 (1)	2.9 (1)	26.5 (9)	35.3 (12)	8.8 (3)	23.5 (8)	2.9 (1)
Staff Orientation Toward Elderly	30.6 (11)	33.5 (12)	25.0 (9)	4.6 (2)	—	5.6 (2)	2.9 (1)	38.2 (13)	20.6 (7)	11.8 (4)	17.6 (6)	8.8 (3)
Matching Staff Educ. with Duties	13.9 (5)	58.3 (21)	16.7 (6)	—	—	11.1 (4)	—	18.2 (6)	36.4 (12)	12.1 (4)	27.3 (9)	6.1 (2)
Service Standards	22.2 (8)	66.7 (24)	5.6 (2)	2.8 (1)	—	2.8 (1)	—	44.1 (15)	35.3 (12)	8.8 (3)	11.8 (4)	—

Coordination of Service Standards.....	10.8 (4)	56.8 (21)	13.5 (5)	2.7 (1)	10.8 (4)	5.4 (2)	2.9 (1)	20.6 (7)	35.3 (12)	20.6 (7)	17.6 (6)	2.9 (1)
Priorization of Client Needs.....	13.9 (5)	52.8 (19)	11.1 (4)	—	5.6 (2)	16.7 (6)	—	18.2 (6)	27.3 (9)	21.2 (7)	24.2 (8)	9.1 (3)
Program Evaluation.....	2.9 (1)	45.7 (16)	42.9 (15)	5.7 (2)	—	2.9 (1)	—	14.7 (5)	38.2 (13)	17.6 (6)	26.5 (9)	2.9 (1)
Ease of Access to Services.....	38.9 (14)	38.9 (14)	11.1 (4)	8.3 (3)	—	2.8 (1)	3.0 (1)	24.2 (8)	39.4 (13)	18.2 (6)	12.1 (4)	3.0 (1)
Appropriate Placement of Clients.....	5.6 (2)	63.9 (23)	19.4 (7)	2.8 (1)	—	8.3 (3)	—	27.3 (9)	30.3 (10)	18.2 (6)	18.2 (6)	6.1 (2)
Speed of Response to Client Needs.....	27.0 (10)	45.9 (17)	18.9 (7)	5.4 (2)	—	2.7 (1)	3.0 (1)	24.2 (8)	42.4 (14)	15.2 (5)	12.1 (4)	3.0 (1)
ALL RESPONSES.....	15.6% (99)	55.4% (352)	18.9% (120)	3.6% (23)	1.6% (10)	4.9% (31)	1.6% (9)	29.6% (173)	34.0% (199)	16.1% (94)	14.7% (86)	4.1% (24)
Excluding No Opinion/N.A.	16.6%	59.1%	20.1%	3.9%	—%	—%	1.9%	36.4%	41.9%	19.8%	—%	—%

Table 2D.8 — Individual Agencies' Assessments of and Probability of Own and System Participation in Functions.

Function	Own					System						
	Exc.	Good	Fair	Poor	No Opin.	Not Applic.	Exc.	Good	Fair	Poor	No Opin.	Not Applic.
Uniform Client Assessment	33.3% (13)	41.0% (16)	2.6% (1)	7.7% (3)	7.7% (3)	7.7% (3)	15.4% (6)	17.9% (7)	33.3% (13)	15.4% (6)	12.8% (5)	5.1% (2)
Uniform Program Standards	23.7 (9)	52.6 (20)	7.9 (3)	—	10.5 (4)	5.3 (2)	2.7 (1)	29.7 (11)	37.8 (14)	8.1 (3)	16.2 (6)	5.4 (2)
Centralized Record Keeping	15.0 (6)	37.5 (15)	20.0 (8)	15.0 (6)	7.5 (3)	5.0 (2)	5.3 (2)	15.8 (6)	26.3 (10)	31.6 (12)	15.8 (6)	5.3 (2)
Centralized Referral System	22.5 (9)	45.0 (18)	12.5 (5)	10.0 (4)	2.5 (1)	7.5 (3)	7.7 (3)	20.5 (8)	41.0 (16)	12.8 (5)	12.8 (5)	5.1 (2)
Centralized Case Coordination	23.1 (9)	33.3 (13)	17.9 (7)	10.3 (4)	10.3 (4)	5.1 (2)	7.9 (3)	15.8 (6)	28.9 (11)	23.7 (9)	18.4 (7)	5.3 (2)
Coordinated Staff Hiring	7.7 (3)	15.4 (6)	12.8 (5)	30.8 (12)	5.1 (2)	28.2 (11)	—	7.9 (3)	15.8 (6)	47.4 (18)	10.5 (4)	18.4 (7)
Coordinated Staff Deployment	10.5 (4)	26.3 (10)	15.8 (6)	26.3 (10)	5.3 (2)	15.8 (6)	2.7 (1)	16.2 (6)	24.3 (9)	37.8 (14)	10.8 (4)	8.1 (3)
Coordinated Communication with Govt.	20.5 (8)	53.8 (21)	12.8 (5)	2.6 (1)	7.7 (3)	2.6 (1)	2.6 (1)	31.6 (12)	47.4 (18)	5.3 (2)	10.5 (4)	2.6 (1)
Amalgamation of Identical Services	15.8 (6)	28.9 (11)	5.3 (2)	21.1 (8)	2.6 (1)	26.3 (10)	—	13.2 (5)	36.8 (14)	28.9 (11)	5.3 (2)	15.8 (6)
Coordinated Geriatric Education	42.1 (16)	44.7 (17)	2.6 (1)	—	2.6 (1)	7.9 (3)	16.2 (6)	48.6 (18)	16.2 (6)	2.7 (1)	10.8 (4)	5.4 (2)
Involving M.D.'s in Ass't/Referral	44.7 (17)	34.2 (13)	7.9 (3)	2.6 (1)	—	10.5 (5)	11.1 (4)	23.3 (12)	38.9 (14)	2.8 (1)	8.3 (3)	5.6 (2)

Integration Hosp./	23.7	36.8	18.4	7.9	2.6	10.5	—	24.3	35.1	27.0	8.1	5.4
Spec. Care Home/	(9)	(14)	(7)	(3)	(1)	(4)	—	(9)	(13)	(10)	(3)	(2)
munity Services.....												
Coordinating Screen-	36.8	28.9	15.8	—	5.3	13.2	2.7	43.2	35.1	—	10.8	8.1
ing of Risk Elderly.....	(14)	(11)	(6)	—	(2)	(5)	(1)	(16)	(13)	—	(4)	(3)
Coordinated Program	28.9	44.7	15.8	2.6	2.6	5.3	8.1	32.4	37.8	8.1	10.8	2.7
Evaluation.....	(11)	(17)	(6)	(1)	(1)	(2)	(3)	(12)	(14)	(3)	(4)	(1)
Centralized Waiting	31.6	31.6	13.2	7.9	2.6	13.2	—	32.4	32.4	21.6	8.1	5.4
Lists/Priorizing.....	(12)	(12)	(5)	(3)	(1)	(5)	—	(12)	(12)	(8)	(3)	(2)
ALL RESPONSES.....	25.2%	37.0%	12.1%	9.7%	5.0%	11.1%	5.5%	25.1%	32.6%	18.4%	11.4%	7.0%
	(146)	(214)	(70)	(56)	(29)	(64)	(31)	(141)	(183)	(103)	(64)	(39)
Excluding No												
Opinion/N.A.	30.0%	44.0%	14.4%	11.6%	—%	—%	6.8%	30.8%	40.0%	22.5%	—%	—%

VIII. IMPLICATIONS OF THE DATA

Saskatoon and district has an expensive, institutionally oriented health and social service system. The information gathered and presented suggests a number of important policy items:

Table 2D.9 — Agency Perception of Services Most Urgently Needed to Improve the Health and Social Service System.

Service	No. Times Mentioned	Weighted Importance *
Central Assessment/ Referrall/Placement		
Mechanism	15	62
Home Care (general)	9	31
Homemaking	8	30
Senior Citizens'		
Activity Centers	7	18
Meals Service	4	17
Level 4 Beds	4	17
Geriatric Education	4	16
Geriatrics Assessment		
Unit in Hospital	4	14
Transportation	4	13
Nursing Services	4	8
Physical Therapy	2	9
Housing	3	4
Level 3 Beds	2	7
Volunteers	2	7
Licensing/Monitoring Private		
Special Care Homes	2	5
Handyman/Repair	2	3
Emergency Services	2	2
Other	6	—

* 5 points for each time a service was listed as first priority, 4 for second priority, etc.

The above results may be compared to the perceptions of senior citizens themselves:

Table 2D.10 — Senior Citizens' Perceptions of Services Most Needed for Retention of Independence for Themselves, and for the Elderly in General.

Service	Needed by Self (%)	Needed by Most Elderly %		
		1st	2nd	3rd
Meals-On-Wheels	57.1	44.4	10.1	11.9
Home Help Services	66.9	34.5	33.8	5.2
Home Nursing	42.9	4.2	18.7	19.4
Patient Follow-Up	14.3	1.4	4.3	3.0
Social Work	9.7	0.0	2.2	5.2
Friendly Visits	28.6	7.0	8.6	9.0
Nite Sitter Service	7.1	0.7	0.0	1.5
Community Alarm System	19.5	3.5	4.3	8.2
Laundry Service	7.8	0.0	5.0	4.5
Transportation	27.3	1.4	9.4	20.9
Foot Care	8.4	0.7	0.7	2.2
Household Modification	16.9	2.1	2.9	9.0

Source: "Adding Life to Years: A Summary and Analysis of Collected Responses," Senior Citizens' Provincial Council, 1977.

- A. Even if one assumes that the District provides Levels 1 - 4 care for an elderly population of 20,000 (as opposed to 15,000 who actually live in the area), there are roughly 8 senior citizens in 100 who are institutionalized. The Senior Citizens' Provincial Council recommends 5.5 to 6.0% as an achievable goal:⁶⁶ advanced nations such as Sweden, Denmark, and the United Kingdom have already demonstrated that such proportions are possible. The Council has also noted that from 1972 to 1977 the number of Level 1 beds in the province declined by 31%, but the number of Level 2 beds increased by 49%.⁶⁸

It has frequently been stated to the Task Force that most Level 1 and 2 beds could be eliminated given adequate public housing and community care services. The Council attributes the decline in Level 1 beds to housing projects; we note that no discernible effect on Level 2 admissions and construction has been evident. Either the concept of reducing demand for Level 2 through community based services needs to be re-examined, or more intensive and far-reaching programs need to be implemented to see whether such a reduction at this level is indeed feasible. Furthermore, whether or not funding mechanisms encourage assessment as Level 2 should be ascertained, and remedied if this is the case.

- B. There is a need for a coordinating mechanism to avoid unnecessary duplication of services, inappropriate placement of clients, and problems of communication among a large number of agencies, particularly in the city. Organizations have themselves noted this deficiency, and have begun to work toward remedies through Age Concern and other channels.

- C. Judging from the survey results, there is a need for a more consistent information gathering and processing mechanism so that programs are measurable and accountable in an accessible way. It might be valuable to develop a single mechanism for this purpose, thereby making more information usable to Government and the public, and reducing the record compilation and search demand on individual agencies, many of which have limited budgets.
- D. Community services for the elderly are probably insufficient to meet existing need, and certainly have not proved extensive enough to exert a significant preventive effect on the system as a whole. While comparative statistics may not be strictly applicable, the following figures show at least some correlation between the availability of home helpers and reduced institutional population.

Table 2D.11 — Elderly Population, Home Helpers per 1,000 and Percentage Institutionalized in Selected Countries.

	Sweden	Denmark	Netherlands	Finland	Sask.	U.K.
Percent Aged 65+ .	14.0	13.0	10.2	8.9	11.0	?
Home Helps/1,000 .	47	23	6	5	4	12.5
% in Homes for the Aged.	5.0	6.0	8.2	10.0	8.0	4.5

Sources: Nathan Markus, "Home Care for the Aged," cited in " 'Adding Life to Years': A Summary and Analysis of Collected Responses"; for Sweden, Denmark, Netherlands, and Finland; Senior Citizens' Provincial Council for Sask. and the U.K.

While we are hesitant to make definitive claims concerning the ultimate preventive effect of a wide range of expanded community programs, we posit that sooner or later society is going to have to find out one way or the other as a matter of economic necessity given the enormous costs of institutionalization. This is aside from the quality of life argument which is still the best philosophical defence of expanding programs promoting independence.

APPENDIX 3. GLOSSARY OF TERMS

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GLOSSARY OF TERMS

Age Cohort: a grouping of selected ages into categories with similar characteristics, e.g. 65-69, 75+ , etc.

Day Centres: facilities normally, but not necessarily attached to nursing homes, providing therapy and other services to senior citizens who continue to reside independently in the community. Clients may attend with varying frequency depending on assessed needs and availability of transportation, etc.

Days Hospitals: facilities attached to acute care hospitals for the purpose of carefully assessing and/or rehabilitating elderly patients. The full range of sophisticated hospital diagnostic and treatment equipment will be available (but not in Day Centres). Discharge goals should be set for all patients. Day Hospitals can prevent or delay inpatient admissions or make earlier discharge possible.

Flexibeds: beds set aside in special and extended care homes which need not be occupied at all times. Their purpose is to provide slack in the system so that urgent cases may be admitted without delay. The concept is similar to the situation in acute care hospitals, where the average daily census of patients is less than the total number of beds set up.

Housing, Basic Public: apartments for senior citizens designed primarily to provide accommodation at reasonable expense for those with low incomes. There are no significant built-in care arrangements or design features to permit significantly incapacitated persons to reside in these complexes.

Housing, Sheltered: units designed to house moderately to substantially incapacitated senior citizens, including the handicapped in wheelchairs and the mildly confused. There are commonly resident supervisors to provide basic monitoring and emergency services, plus electronic equipment attached to a central switchboard to alert the supervisor of potential problems. These units are somewhat more expensive than Basic Public Housing, but could eliminate the need for Levels 1 and 2 care in institutions if properly constructed.

Level 1 Care: roughly 20 minutes of supervisory care per day for clients who are essentially independent.

Level 2 Care: roughly 45 minutes of care per day, involving perhaps

supervision and assistance with personal hygiene and grooming; clients are ambulant with or without mechanical aids, and may have slight to moderate behavior problems.

Level 3 Care: roughly 2 hours per day of extensive supervision and assistance carried out under the guidance of a Registered Nurse or Registered Psychiatric Nurse, with total care directed by the attending physician; significant, though not dangerous emotional and behavioural problems may be present.

Level 4 (Extended) Care: more than 2 hours daily of care under continuing medical supervision, with professional nursing services readily available; level is subdivided into:

Level4a: specialized supervisory care with emphasis on management of advanced mental deterioration.

Level 4b: supportive care designed to arrest or retard deterioration in client condition.

Level 4c: restorative care, with slow paced rehabilitative program designed to improve functional ability so that clients may either return to the home setting, or a lower level of care.

Level 6 Care: acute care requiring round the clock medical/nursing supervision in general hospitals.

M.C.I.C.: the Medical Care Insurance Commission, which is the Government payment agency for physicians, optometrists, and certain other health professionals whose services are insured under the Medical Care Insurance Act.

S.H.S.P.: the Saskatchewan Hospital Services Plan, which finances in-patient and related acute care services as well as Level 4 (Extended) Care.

Vacation Beds: nursing home beds set aside for short-term — usually no longer than a month — institutionalization of clients who normally are cared for in the community, but whose major care providers are temporarily absent. Unlike Flexibed utilization, Vacation Care stays can be planned in advance to ensure close to 100% occupancy.

APPENDIX 4. TASK FORCE MEETINGS AND CONSULTATIONS

APPENDIX 4

TASK FORCE MEETINGS AND CONSULTATIONS

January

- 31: Chairman/Vice-Chairman/Research Director — preliminary planning meeting

February

- 15: Task Force meeting
28: Task Force* with Dr. V. Matthews & Ms. J. Feather

March

- 7: Task Force with Dr. S. L. Skoll, Dr. G. Piper, Dr. C. M. Smith
15: Chairman with Age Concern
20: Task Force* with Dr. V. Matthews & Ms. J. Feather
28— Task Force with Dr. Hatswell, Dr. Hunt, Ms. Jarvis, Mr. Mullens
28: Research Director with Dr. D. Rapelje, Director, Senior Citizens' Department, Niagara Region & staff membes at Sunset Haven Home for the Age, Welland, Ontario (in Welland)
29: Research Director with Miss M. Fraser, Director, Ottawa-Carleton Patient Placement Coordination Service & Assessment Counsellors; Mr. A. Warren, Executive Director, Ottawa-Carleton District Health Council (in Ottawa)
30: Research Director attended University of Ottawa Seminar on Care of & the Aged (in Ottawa)
31:

April

- 3: Research Director with Ms. E. Thompson, Ms. M. Barbour, Ms. C. Ewanchyna, and Ms. D. Collins of the Office of Continuing Care, Province of Manitoba (in Winnipeg)
18: Task Force meeting
24: Research Director with Dr. Skoll, Dr. Hatswell, Mr. Mullens (in Regina)

May

- 2: Task Force with Saskatoon Provisional Board of Health
11: Task Force with Dr. Brocklehurst, Dr. Skoll, Dr. Hunt
17: Task Force* with Dr. R. Hikel, Home Care Director, Province of Saskatchewan
17: Research Director and Board of Directors, Family Service Bureau
23: Task Force* and Saskatoon community-based agencies
24: Task Force* and representatives of Saskatoon senior citizens' groups
25: Task Force* with representatives of Level 1-4 care institutions in Saskatoon

31: Task Force * with representatives of surrounding municipalities

June

13: Task Force meeting

27: Task Force meeting

July

18: Task Force meeting

* Denotes a Subcommittee of the Task Force.

**APPENDIX 5. STREET MAP
OF CENSUS
DISTRICT BOUNDARIES,
SASKATOON**

APPENDIX 5

STREET MAP OF CENSUS DISTRICT BOUNDARIES, SASKATOON

